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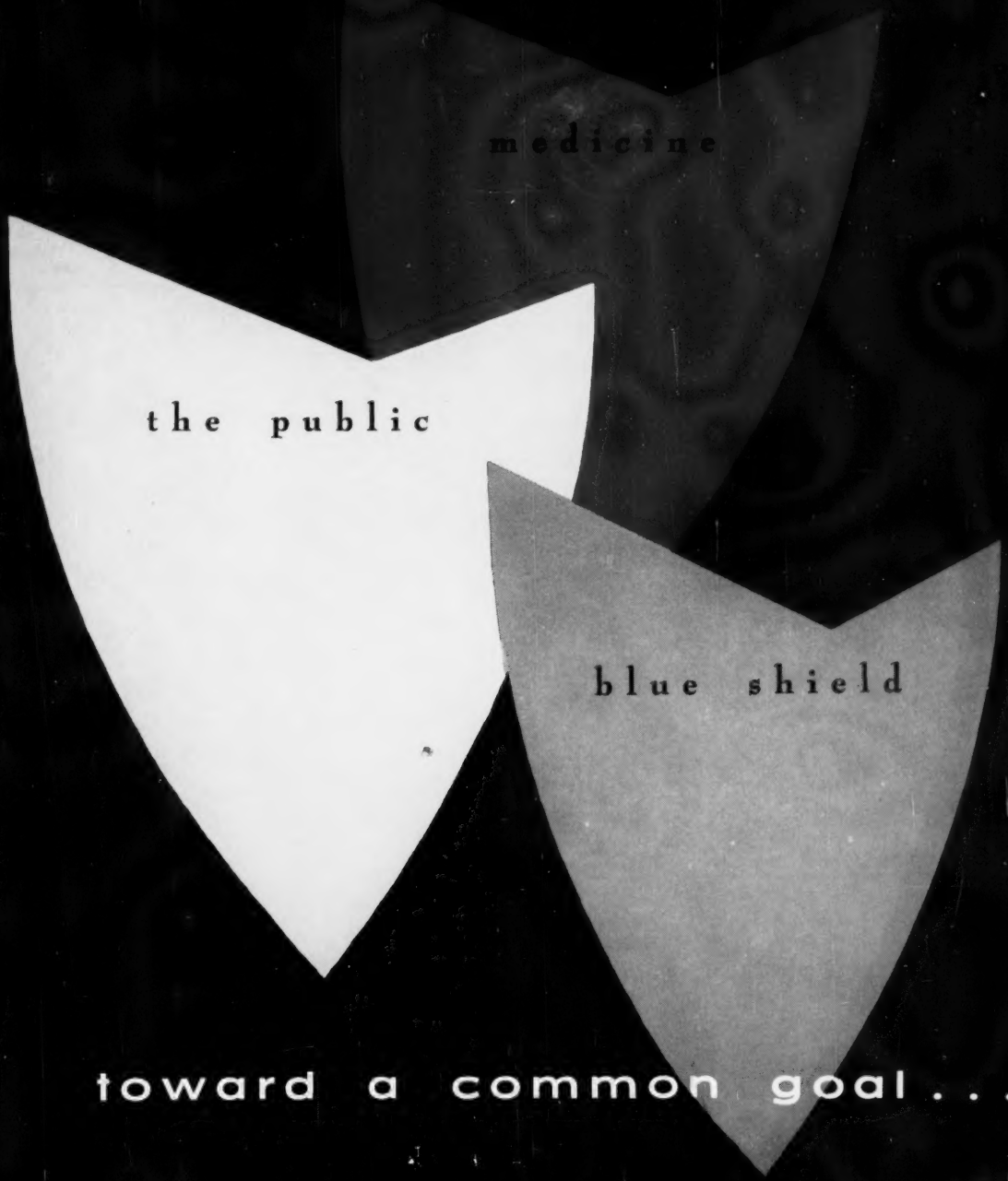

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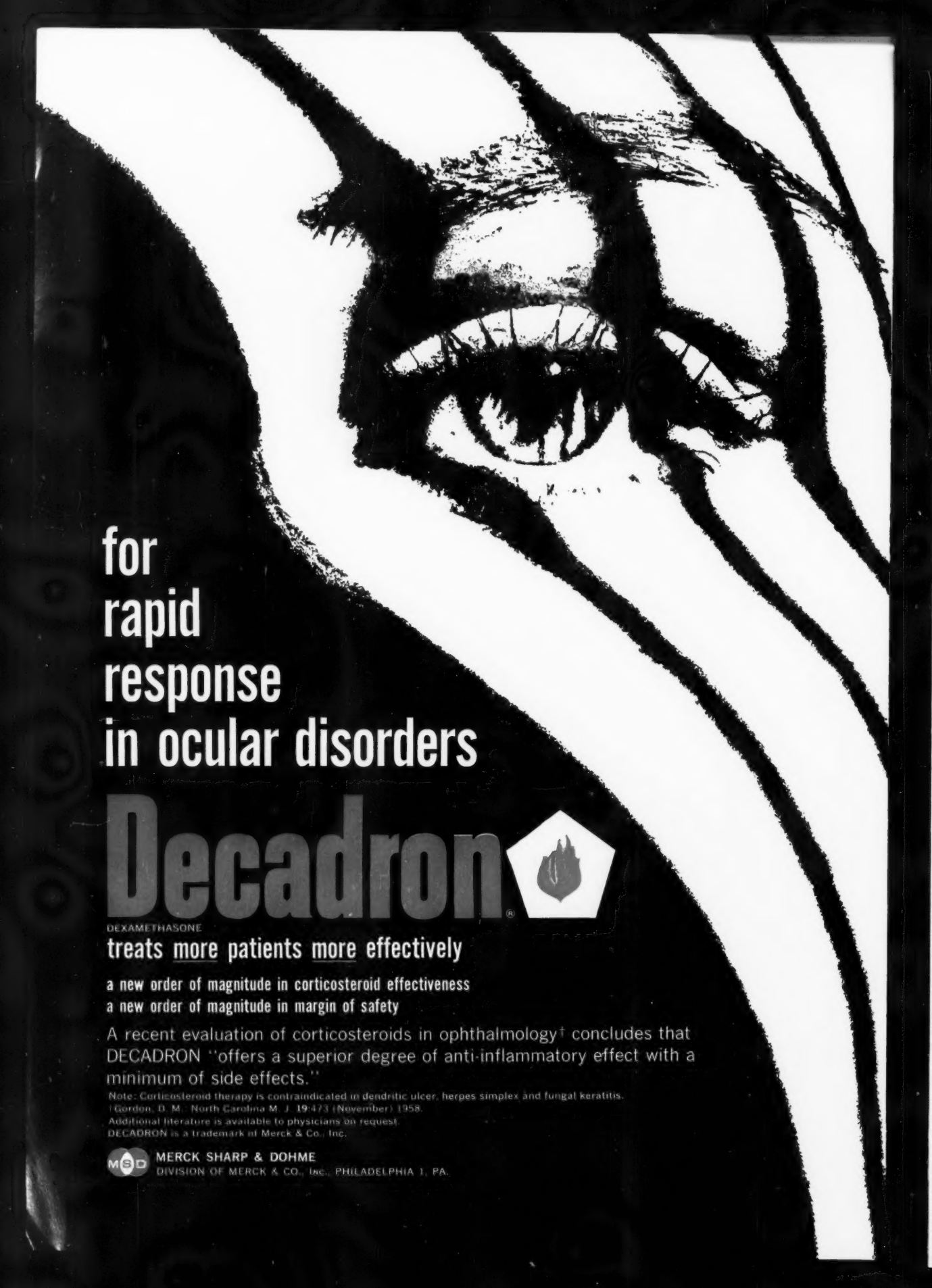
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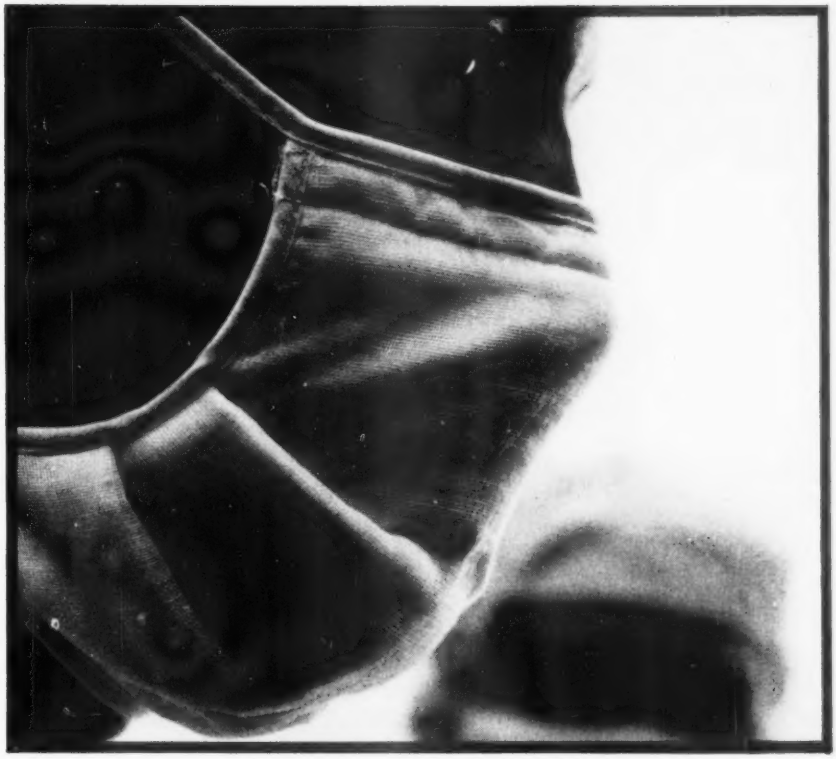

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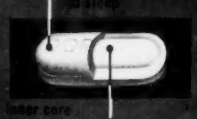

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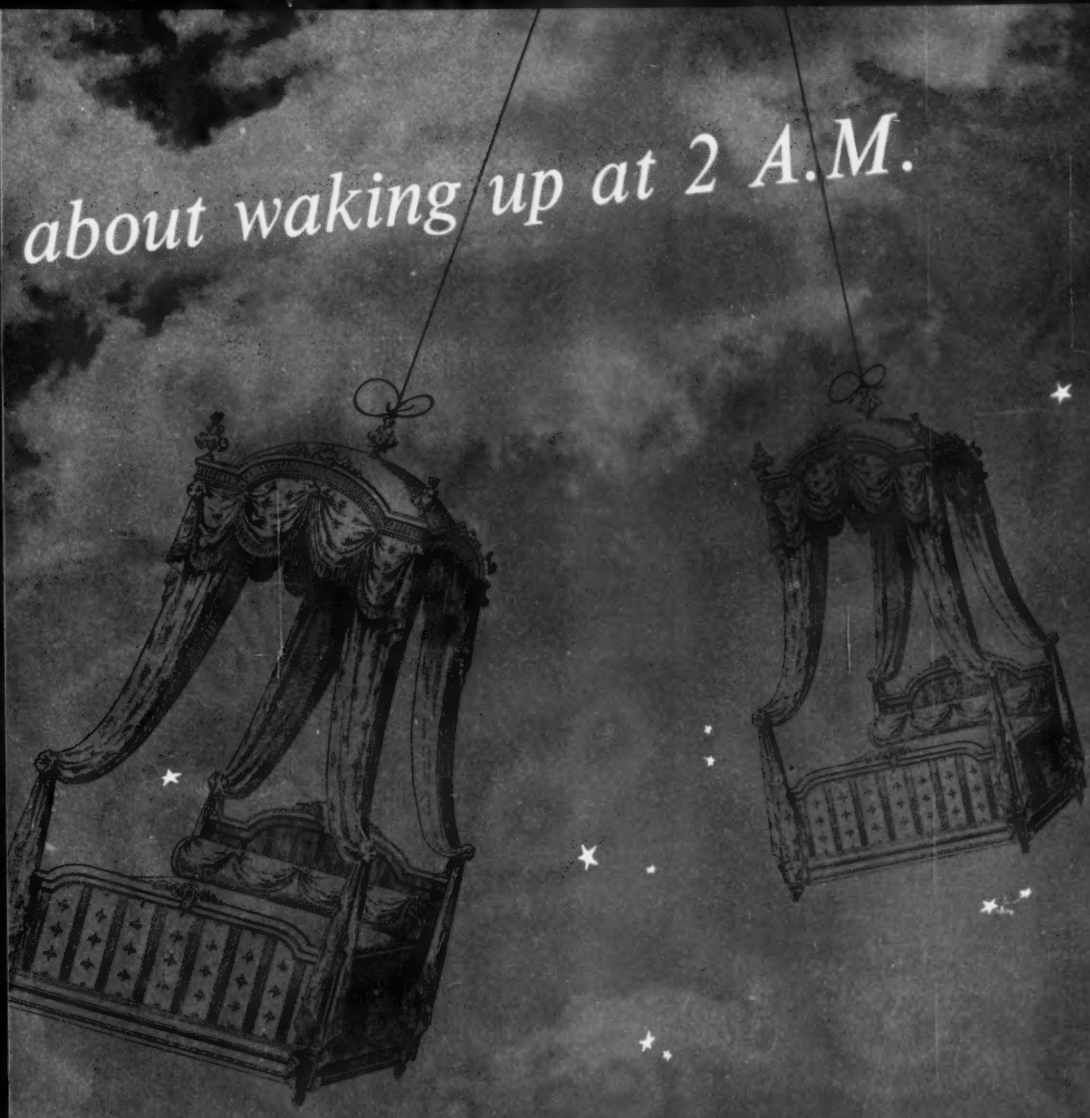

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(Continued on Page 862)

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- **Restores normal sleep**—without hang-over or depressive aftereffects. Usually eliminates need for sedative-hypnotics.

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References:

1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.

2. Current personal communications; in the files of Wallace Laboratories.

3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

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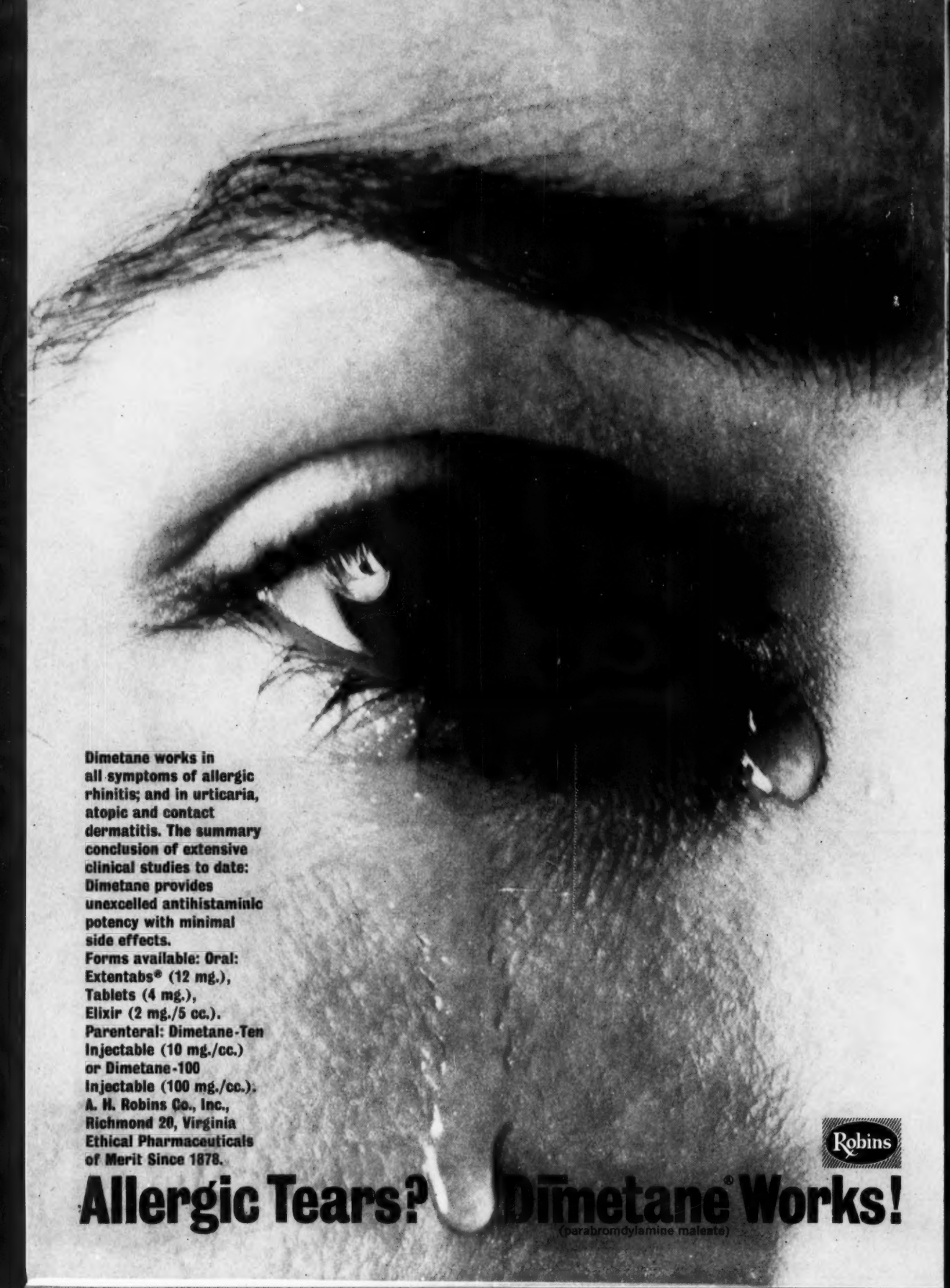

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for
low back pain
and
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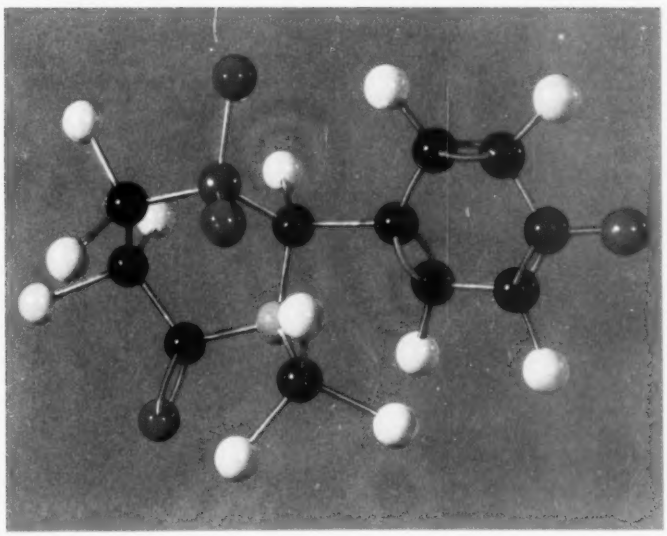
*the first true tranquilaxant**

***Potent* MUSCLE RELAXANT**

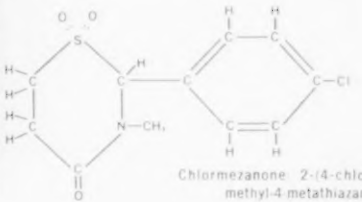
***...Equally effective as a* TRANQUILIZER**

***tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]



Trancopal, a major development of Winthrop research, is a new, orally administered nonhypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4 metathiazanone-1-dioxide

Clinical studies of over 4400 patients by 105 physicians[1] proved Trancopal remarkably effective in musculoskeletal conditions, anxiety and tension states.

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effective in

93%

of 1570 documented cases of

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By relieving muscle spasm and pain, Trancopal permits early and active exercise and physical therapy to accomplish maximal benefits for rapid recovery.

Trancopal

the first true tranquilaxant

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With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work—or play. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

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effective in

88%

of 443 documented cases of

DYSMENORRHEA

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Because of its exceptional calmative property, Trancopal ". . . allows the patient to use his energies in a more productive manner in overcoming his basic problems."[2]

Dosage: 1 or 2 Caplets (100 mg.) orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

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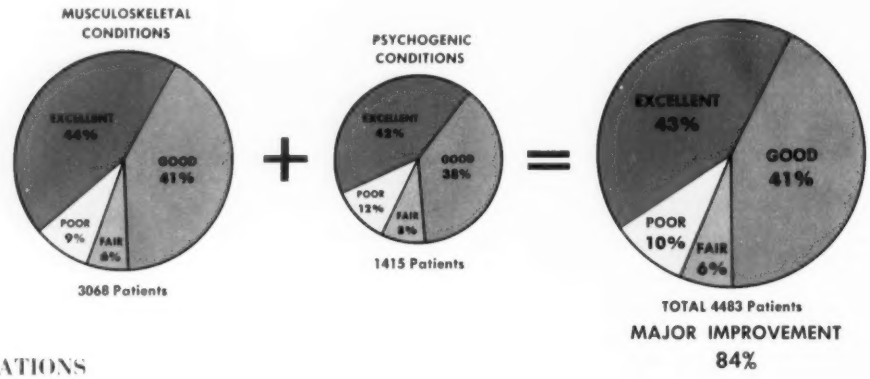
Clinical studies of 4483 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.



INDICATIONS

Musculoskeletal

Low back pain (lumbago)	Disk syndrome
Neck pain (torticollis, etc.)	Fibrositis
Bursitis	Ankle sprain, tennis elbow, etc.
Rheumatoid arthritis	Myositis
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Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Collective Study, Department of Medical Research, Winthrop Laboratories. • 2. Ganz, S.E.: J. Indiana M. A. In press. • 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

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Michigan Clinical Institute

Nineteen Honored at Testimonial Luncheon

Michigan doctors of medicine who are presidents of national medical organizations were honored by their MSMS confreres at the annual Testimonial Luncheon held during the Michigan Clinical Institute on March 12 in Detroit.

By tradition, Michigan's Foremost Family Physician of the year is officially recognized at this time by Medicine and the public.

In addition to the tribute paid physicians, the medical profession also presented Distinguished Health Service Awards to eleven prominent citizens who are making contributions to the health and welfare of the State.

Luncheon co-chairmen were Milton A. Darling, M.D., MSMS president-elect, and G. Thomas McKean, M.D., MSMS Councilor, both of Detroit.

Presentations were made by G. B. Saltonstall, M.D., Charlevoix, MSMS president, and L. Fernald Foster, M.D., chairman, MSMS Committee on Awards.

Photos of the honorees and awardees appear on the following pages.

HONOREES

J. Edward Berk, M.D., Detroit
President, American Gastroscopic Society

Fred J. Drolett, M.D., Lansing
Michigan's Foremost Family Physician for 1958

C. Leslie Mitchell, M.D., Detroit
President, American Orthopedic Association

Hermann K. B. Pinkus, M.D., Monroe
President, Society for Investigative Dermatology

John W. Rebuck, M.D., Detroit
President, International Reticulo-Endothelial Society

Lawrence Reynolds, M.D., Detroit
President, American College of Radiology

W. H. Steffensen, M.D., Grand Rapids
President, American Society of Plastic and Reconstructive Surgery

John M. Wellman, M.D., Lansing
President, Frederick A. Coller Surgical Society

AWARDEES

Jay C. Ketchum, Detroit
Senator Frank Andrews, Hillman
Representative Willard I. Bowerman, Jr., Lansing
Adrian Daily Telegram
Kalamazoo Gazette
WJBK-TV, Detroit
WABJ, Adrian
WCBY, Cheboygan
WHLS, Port Huron
WKAR, East Lansing
WMTE, Manistee

Michigan's Foremost Family Physician for 1958 proudly accepts his illuminated scroll from President Saltonstall as Mrs. Drolett and son, L. A. Drolett, M.D., share the proud moment.

With President Saltonstall and Doctor Drolett *(seated right)* are presidents of national medical organizations. Seated left to right are C. Leslie Mitchell, M.D., and J. Edward Berk, M.D. Standing from left are John W. Rebuck, M.D., Hermann K. B. Pinkus, M.D., and W. H. Steffensen, M.D. (Absent due to illness was John M. Wellman, M.D., Lansing.)

Lawrence Reynolds, M.D., Detroit, president of the American College of Radiology, is given his award by MSMS President-elect Milton A. Darling, M.D.

Michigan Senator Frank Andrews, Hillman, was honored by MSMS for his exemplary devotion to the highest quality of medical education and health care.

♦

For his outstanding contribution to Michigan medicine and the public, Mr. Jay C. Ketchum *(right)* for seventeen years the executive vice president and general manager of Michigan Medical Service, accepts his scroll from G. Thomas McKean, M.D.

Managing Director of Detroit's WJBK-TV, Mr. William Michaels, accepts his station's award for co-operation in producing the "Family Doctor" show, an hour-long feature presented during the 1958 Annual Session.

The Kalamazoo Gazette award for cosponsorship of medical forums was accepted by Mr. Deen Malotte, promotion manager.

WCBY, Cheboygan, sent Mr. John King to accept the MSMS award being presented by President Saltonstall.

Station Manager Donald Dean accepted the award for radio station WABJ, Adrian.

Radio station WKAR, East Lansing, is represented by Mr. Larry Frymire, station manager.

Representing radio station WMTE, Manistee, was Mr. James R. Sumbler, the broadcasting company's president.

PR REPORT

Public Relations Boosted

Record Four Thousand Service Club Members Hear M. D. Speakers During MCI

More people heard more M.D. speakers at more luncheon clubs during the Michigan Clinical Institute than ever before during any state medical meeting.

Estimates are that during this single week more than 4,000 Detroit area businessmen and civic leaders got the word on the scientific and economic sides of medicine direct from doctors of medicine.

A record total of forty-three service clubs in the Detroit metropolitan area hosted as many physician speakers-of-the-day.

The speaker program was instituted by the MSMS PR Committee and implemented by the public relations staff.

Commenting on the large number of club invitations this year, R. Wallace Teed, M.D., PR Committee Chairman, said, "We have long believed that one of the finest ways of telling medicine's story is through personal contact. The speaker's program of the MCI has the virtue of this personal touch yet reaches a large number of influential people who want to know of the advances and goals of modern Michigan medicine. We are deeply indebted to the many physicians who volunteered to talk to this important audience."

Dr. Teed added that present plans call for a similar program to be arranged in connection with the 1960 Michigan Clinical Institute to be held in Detroit, March 8-9-10-11.

James E. Lofstrom, M.D., Detroit, has a pre-prandial chat with Exchange Club President, G. W. Bartlum.

MCI SERVICE CLUB SPEAKERS—1959

North Detroit Kiwanis Club, Francis S. Gerbasi, M.D.
Harper Woods Kiwanis Club, C. J. Hipps, M.D., Detroit
U & I Club, R. H. Pino, M.D., Detroit
B'nai B'rith, R. A. Braun, M.D., Detroit
Birmingham Kiwanis Club, Everette Gustafson, M.D., Pontiac
Warrendale Kiwanis Club, P. G. S. Beckett, M.D., Detroit
Centerline Rotary Club, Everette Gustafson, M.D., Pontiac
Southwest Kiwanis Club, Francis S. Gerbasi, M.D., Detroit
Central Kiwanis Club, J. C. Gemeroy, M.D., Detroit
Garden City Lions, Robert Goldsmith, M.D., Ann Arbor
Dearborn Lions, Wm. A. Willoughby, M.D., Detroit
Ludington Lions, W. F. Sutter, M.D., Ludington
Tabernacle Neighborhood Nursery Parent Association, David Freides, Ph.D., Detroit
St. Clair Lions, J. F. Gerrits, M.D., St. Clair
Wyandotte Kiwanis Club, David Barsky, M.D.
Trenton Kiwanis Club, L. A. Comstock, M.D., Trenton
Kiwanis No. 1 Club, W. M. LeFevre, M.D., Muskegon
Detroit Northeastern Kiwanis, G. E. Millard, M.D.
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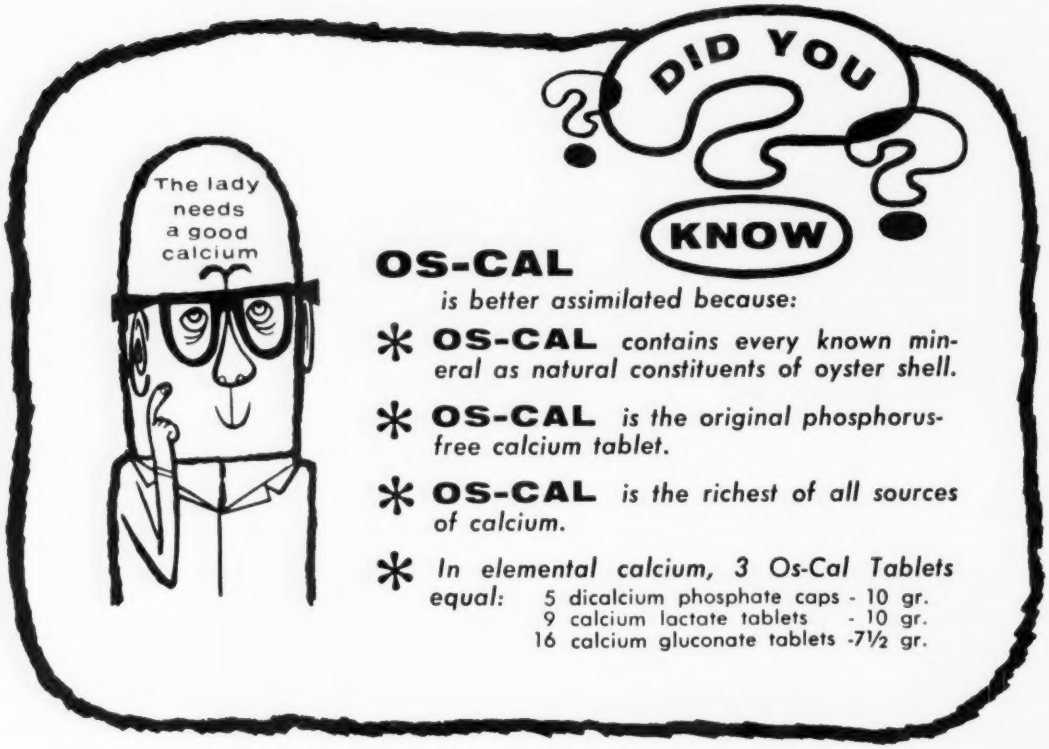
Downtown Rotary Club, P. L. Cusick, M.D., Detroit
Port Huron Kiwanis, N. G. Douvas, M.D., Port Huron
Wayne Kiwanis Club, A. R. Parker, M.D., Wayne
Berkley Rotary Club, W. A. Willoughby, M.D., Detroit
Dearborn Outer Drive Kiwanis Club, W. A. Willoughby, M.D., Detroit
Detroit Exchange Club, J. E. Lofstrom, M.D., Detroit
Lions Club of Detroit, A. D. Ruedemann, Sr., M.D.
Division No. 4 Kiwanis Club, Maurice B. Wehr, M.D., Detroit
Industrial Center Kiwanis Club, Gerald Wilson, M.D., Detroit
Art Center Kiwanis Club, J. S. Ward, M.D., Detroit
Denby Kiwanis Club, R. W. Howell, M.D., Detroit
Garden City Rotary Club, L. P. Haefele, M.D.
Excaliber Club, P. L. Cusick, M.D., Detroit
Roseville Kiwanis Club, H. A. Dunlap, M.D., Detroit
Highland Park Rotary Club, H. C. Saltzstein, M.D., Detroit
Warren Kiwanis Club, Everette Gustafson, M.D., Pontiac
Roseville Rotary Club, H. L. Weston, M.D., Detroit
Retired Men's Fellowship, A. Hazen Price, M.D., Detroit
Northwest Detroit Kiwanis Club, R. A. Braun, M.D., Detroit
Mt. Clemens Kiwanis Club, C. P. Kuhn, M.D., Detroit
Warrendale Kiwanis Club, P. G. S. Beckett, M.D., Detroit
Arenac Eastern Lions Club, J. R. Gehman, M.D., Standish

Paul L. Cusick, M.D., Detroit, who headed the operating team which performed the televised cataract extraction, is shown *(second from left)* at one of the two luncheon clubs he addressed.

Service Clubs Hear M. D. Speakers—Continued

A. D. Ruedemann, Sr., M.D. *(center)* chats with hosts before his address to the Lions Club meeting at the Statler-Hilton Hotel.

Kiwanis No. 1, one of Detroit's largest clubs, heard Wm. M. LeFevre, M.D. *(right)*, Muskegon, MSMS Councilor.



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Natural Trace Minerals
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Natural Trace Minerals
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Vitamins A-D-C-B6 and K
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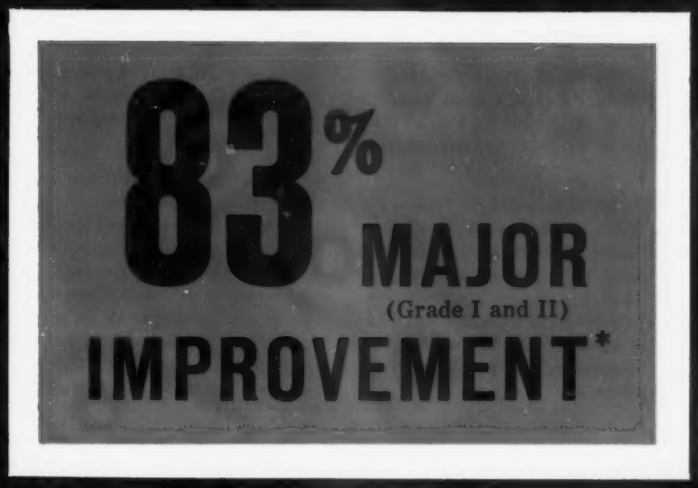
*HARDY, J. A.: *Obstet. & Gynec.* (Nov., 1956)



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*Using combined drug therapy with PLAQUENIL® or Aralen® as maintenance therapy. With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
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Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg. (2 or 3 tablets) daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

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Aralen (brand of chloroquine) and Plaquenil (brand of hydroxychloroquine), trademarks reg. U.S. Pat. Off.

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WHAT THEY SAID ABOUT THE 1959 MICHIGAN CLINICAL INSTITUTE

I. S. Ravdin, M.D., Hospital of the University of Pennsylvania (guest essayist): "It was a great pleasure for me to be able to attend the Michigan Clinical Institute and I am only sorry that I could not stay longer."

* * *

Wendell G. Scott, M.D., Scott Radiological Group, St. Louis (guest essayist): "First of all, I want to tell you how much I enjoyed the meeting of the Michigan Clinical Institute. You certainly have a well run meeting. Dr. Howard Doub was most gracious in his hospitality and was the epitomy of the famed Michigan ubiquitous host. Please express my pleasure and appreciation to the members of your organization for the opportunity of participating in your meeting."

* * *

J. Vogel, Captain, M.C., U. S. Navy, New London, Conn. (guest essayist): "I would like to take this opportunity to tell you how very much I enjoyed being with your group, and to express my admiration for the outstanding manner in which the many details incident to these meetings were handled. Dr. W. S. Reveno and his program committee, and so many others did a magnificent job and are deserving of much credit. It was a pleasure to have participated and I trust my small share was of some value to the program."

* * *

Leo A. Hoegh, Executive Office of the President, Washington, D. C. (guest essayist): "I appreciate very much receiving the nice comments relative to my recent appearance on the program of the Michigan Clinical Institute. It was a fine audience and I enjoyed talking to them."

* * *

A. C. McGuinness, M.D., U. S. Department of Health, Education and Welfare, Washington, D. C. (guest essayist): "I much enjoyed the privilege of presenting my views before the 1959 Michigan Clinical Institute."

* * *

W. L. Estes, Jr., M.D., Bethlehem, Pennsylvania (guest essayist): "It was a great pleasure to participate in the program of the Michigan Clinical Institute. It is always a pleasant project to visit in Detroit as the men are so hospitable and do such a superb job of taking care of the visiting speakers."

* * *

James McGarrigle, Staff Photographer, *Detroit Times*: "I would like to thank the staff of the Michigan State Medical Society for the wonderful co-operation we photographers received the night of the eye operation at Providence Hospital. We of the press know the importance of this great piece of surgery and its miraculous gift of prolonged sight to the patient. I can only say 'amazing.' I'm glad that I was there. It was gratifying to know that you liked the photographic coverage but may I remind you that this was only possible through the efficient public relations of all those involved. I look forward with pleasure to any future assignments with the Michigan State Medical Society."

* * *

Francis Boyer, Chairman of the Board, Smith Kline & French Laboratories: "I was pleased to hear that the television reception, both on the screen and by our medical and lay audiences was good at the Michigan Clinical Institute. Our crew for these color television activities spoke of the fine co-operation they received from the participating physicians—a major factor in producing a successful series of programs. I hope that SKF and the Michigan Clinical Institute will soon have an opportunity to work together again."

* * *

Richard G. Pearce, D.V.M., Royal Oak, official, Southeastern Michigan Veterinary Medical Association: "I want to thank the Medical Association for the invitation extended to us during the recent Michigan Clinical Institute. As you probably know there are several of our members who availed themselves of this fine meeting and each derived something of benefit from it. This type of interprofessional communication is highly desirable and is the type of relationship that benefits our mutual professions and in the long run benefits the public. We hope to be able to return to you an invitation to our state veterinary meeting in June."

* * *

Carroll Cutler, Gray Audograph Corporation (exhibitor): "Let me congratulate you on an extremely well run meeting. I have attended medical meetings all over the country, and believe me I have yet to see one as capably and efficiently handled as the past Michigan Clinical Institute. Many best wishes for many more successful meetings such as the last one.

* * *

Charles M. Powell, Jr., American Cyanamid Company (exhibitor): "We enjoyed attending the Michigan Clinical this year, as every year. Our booth location this year was so good that our men attending thought we ought to obtain this identical location in 1960."

* * *

Harvey C. Hallum, Mead Johnson & Company (exhibitor): "I am anxious for you to know how much we appreciated being permitted to participate in your conference. Also, I want to compliment your committee for the splendid program which they developed."

Improved health standards have been a major stabilizing influence on marriage and the family in recent years, according to *Health Information Foundation*. Because of declining death rates, the average parent today has a much better chance of living to see his children grow up; fewer children die; orphanhood has largely disappeared as a social problem.

the means *(second to none)*

to end **nausea and vomiting**

Trilafon

INJECTION • SUPPOSITORIES • REPETABS • TABLETS

- *leads* all phenothiazines in effective antinauseant action
- *frees* patients from daytime drowsiness
- *avoids* hypotension
- *proved* and *published* effectiveness in practically all types of nausea or emesis

FOR RAPID CONTROL OF SEVERE VOMITING

TRILAFON INJECTION

5 mg. ampul of 1 cc.

Relief usually in 10 minutes[1]...nausea and vomiting controlled in up to 97% of patients[2]... virtually no injection pain.

ALSO NEW TRILAFON SUPPOSITORIES

4 mg. and 8 mg.

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8 mg.—4 mg. in outer layer for *prompt effect*, 4 mg. in inner core for *prolonged action*

2 mg. and 4 mg.

(1) Ernst, E. M., and Snyder, A. M.: Pennsylvania M. J. *61*:355, 1958.

(2) Preisig, R., and Landman, M. E.: Am. Pract. & Digest Treat. *9*:740, 1958.

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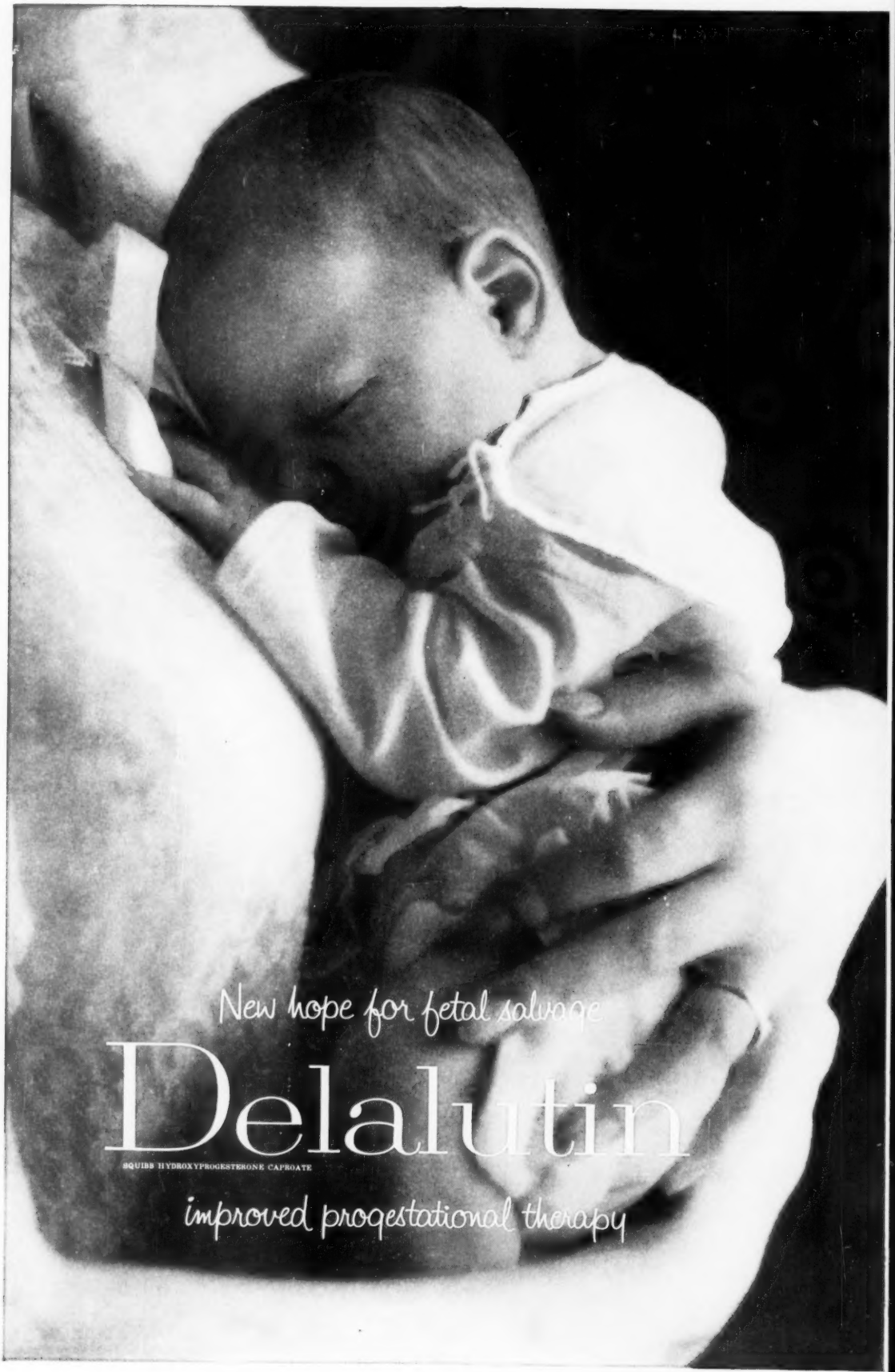
New hope for fetal salvage
Delalutin
SQUIBB HYDROXYPROGESTERONE CAPROATE
improved progestational therapy

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.[1] Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.
A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; post-partum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

Rural Health Conference Hits Record

A capacity crowd attended the Twelfth Annual Michigan Rural Health Conference at Kellogg Center in East Lansing on April 8 and 9. The Conference theme was "Safe Roads to Health."

Ralph H. Pino, M.D., Detroit, receives scroll for his activity in interesting young people in embarking on medical or allied health careers. The award was presented during the Michigan Rural Health Conference by Hugh W. Brenneman, MHC Secretary.

More than 60 recognized experts covered such topics as milk inspection, danger of excessive use of antibiotics, animal diseases, community and school health improvement programs, highway safety, and many other health and safety subjects.

A new feature of this year's conference was the Health Careers Day Program. More than forty public and parochial high schools, from very small to large metropolitan cities throughout Michigan, sent student representatives and counselors to hear stimulating talks. Outstanding speakers told the young registrants about the more than fifty health careers where there is a great need and excellent opportunity for more students to enter their professions. More than 300 students took part in this special conference.

A highlight of the two-day meeting was the presentation of awards to two Michigan M.D.'s who were recognized for their health activities.

At the Wednesday luncheon, Ralph H. Pino, M.D., Detroit, was presented with a scroll by MHC Secretary Hugh W. Brenneman. Dr. Pino was recognized "for his dedicated efforts over a number of years in developing a greater knowledge and interest among students in a medical or health career and for his outstanding leadership in the establishment of the Michigan Health Council Health Careers Committee in 1958 which he serves so ably as chairman."

John D. Monroe, M.D., Health Director in Oakland County, received the annual Public Health Award at a separate ceremony.

Announcement was made at the banquet that the 15th National Conference on Rural Health, sponsored by the American Medical Association, will be held in Grand Rapids on February 25-27, 1960.

Through the special cooperation of the Michigan Foundation for Medical and Health Education, the Michigan Health Council is planning several regional health conferences prior to the National Conference, in order to stimulate the interest of Michigan residents in attending the Conference in Grand Rapids. The regional conferences also will feature programs on rural health, community and school health, and will have special sessions on health careers for high school and college students located in the areas where the regional conferences are to be held.

POPULATION PATTERN CHANGING?

Is our population pattern changing? Four states in the country, Nevada, Arizona, California and Florida, are expected to have the largest population growth between 1955 and 1970, according to the current edition of *Patterns of Disease,* prepared by Parke, Davis & Company.

Nevada's population is expected to rise 67 per cent, Arizona's 66 per cent, California's 54 per cent and Florida's 53 per cent.

Three states are losing population: Mississippi, Oklahoma and Arkansas.

Regionally, the most rapid population increases are in the Pacific States, followed by the Mountain and the five East North Central States.

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Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
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Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (1/4 gr.)	16.2 mg.

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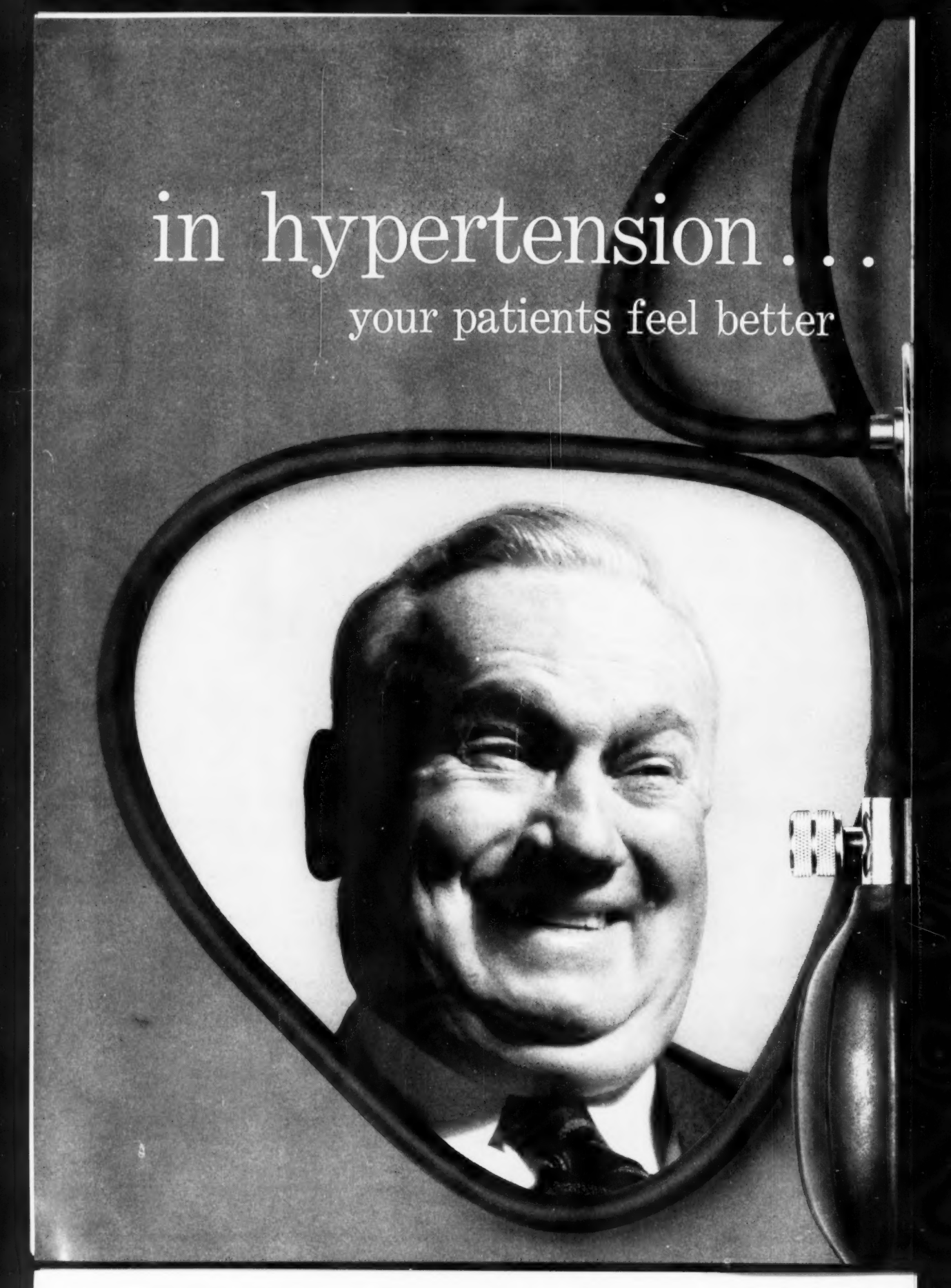
in hypertension . . .
your patients feel better

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blood pressure
is controlled
safely and
effectively

The hypertensive under treatment is frequently burdened with side effects of therapy including states of depression, fatigue, and lethargy. He finds little joy left in his life and laughter is almost a forgotten experience.

With RAUTENSIN and RAUVERA, two unique and dependable antihypertensive agents, patients feel better, have a brighter outlook and blood pressure is safely reduced.

in mild hypertension

RAUTENSIN provides smoother antihypertensive action with no sudden rebounds or abrupt declines, and can be given over long periods of time without impairing mental alertness, producing excessive lethargy or drowsiness. When tachycardia is present, RAUTENSIN slows heart rate 10 to 15 per cent. RAUTENSIN is less likely to cause mental depression.[1] The apprehensive hypertensive is calmed, yet side actions are " . . . either completely absent or so mild as to be inconsequential."[2]

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each tablet contains 2 mg. of the purified alseroxylon complex of Rauwolfia serpentina

Dosage: For the first 20 to 30 days, 2 tablets (4 mg.) once daily, at bedtime. Thereafter, a maintenance dose of 1 tablet (2 mg.) daily will suffice for most patients.

in moderate to severe hypertension

RAUVERA produces smooth and steady antihypertensive action which persists over the entire twenty-four hours without peaks and valleys . . . no "saw tooth" effect. Patients show a marked subjective as well as objective improvement with a significant drop in blood pressure, yet with a very low incidence of side effects.[3] Abrupt rise in blood pressure does not occur even when therapy is interrupted.[4] Tolerance does not develop on prolonged administration. Sensitization reactions or postural hypotension do not occur. Headaches, fatigue, insomnia and "heart consciousness" rapidly disappear, leaving the patient feeling well and asymptomatic.

RAUVERA®

each tablet contains 1 mg. of purified alseroxylon complex of Rauwolfia serpentina and 3 mg. alkavervir (Veratrum viride fraction)

Dosage: One tablet 3 or 4 times daily, ideally after meals, at intervals of not less than 4 hours.

1. Moyer, J. H.: Dennis, E., and Ford, R.: Arch. Int. Med. *96*:530, 1955.
2. Terman, L. A.: Illinois M. J. *3*:67, 1957.
3. La Barbera, J. F.: M. Rec. & Ann. *50*:242, 1956.
4. Bendig, A.: New York J. Med. *66*:2523, 1956.

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Cancer Comment

This column is sponsored by the Michigan Cancer Co-ordinating Committee, Box 539, Lansing 3, Michigan

THE IMPORTANCE OF THE SIGMOIDOSCOPIC EXAMINATION

We are all aware of the multiple benign processes involving the rectal area. Beyond that, within the United States there are approximately 35,000 deaths annually from carcinoma of the colon and rectum. This, in addition to the frequent presence of so-called pre-cancerous lesions, makes the examination not only worthwhile, but an integral part of any complete and thorough physical examination.

Indications for a sigmoidoscopic examination are (1) the completion of a thorough health appraisal examination, (2) awareness of blood in the stool, (3) any type of rectal pain, (4) any possible mass in the rectal area, (5) any rectal disturbance or a pruritus, and (6) any possible change in bowel habits.

Procedure.—It is highly desirable to feel first rather than to look. Do a careful and cautious digital examination preceding the sigmoidoscopic procedure. Seventy-five per cent of the malignancies of the lower portion of the bowel may be reached by the examining finger. Preparation for a sigmoidoscopic procedure should not be made a particular routine. Seventy-five per cent of all individuals do not need any preparation whatsoever and, specifically, patients with chronic ulcerative colitis should not have any preparation, since the undisturbed rectal mucosa should be observed, and preparation may well remove the clue. If an enema is necessary, the sodium phosphate disposable units in plastic containers are a tremendous boon to simplifying this procedure. Saline, or even tap water, may be used.

Position for the sigmoidoscopic examination: The tilt table, and there are some beautiful ones on the market, are a tremendous aid to a satisfactory sigmoidoscopic procedure. They permit greater relaxation and a more comfortable position for the patient and provide superiority of ease with which the instrument can be inserted by the physician. The left lateral position is good for ill or elderly patients. Short of the tilt table, the knee-chest position still remains the most desirable one. Again, it is desirable to put lubricant around the anal area rather than to lubricate the entire scope before inserting it.

Utilizing the left index finger for preparation it is possible to reach to approximately ten cms. Many things may be felt by this procedure and it serves to dilate the rectal sphincter. The instruments to be employed should include the physician's own personal preference for a sigmoidoscopic, a proctoscope, suction tip, biopsy bottle and biopsy forceps. The total layout set for a sigmoidoscopic examination should not cost over $75.00.

The art of a sigmoidoscopic examination includes a quick, rapid procedure done without air pressure and largely with direct observation. In other words, insert the scope under direct vision and look as the scope is withdrawn. If there are any blind spots, withdraw the scope and start again. In approximately twenty-five per cent of individuals, it is not possible to pass the rectosigmoid junction.

Remember the rectal ampulla is the responsibility of the sigmoidoscopist and not the responsibility of the radiologist.

—H. M. Pollard, M.D.

Experience has shown that malignant degeneration does occur in benign gastric polyps. In one hospital, 5 of 32 patients were found to have cancer in association with their gastric polyps.

* * *

The diagnosis of gastric polyps depends on both roentgenologic and gastroscopic examinations.

* * *

Cytological examination of discharges from the nipple seems destined to become an important adjuvant to the clinical diagnosis of certain breast lesions and requires close co-operation between the cytologist and clinicians in charge of the patient.

* * *

The National Cancer Institute, Pathology Section, has set up a Geographical Pathology unit to study the distribution of cancer in certain ethnic groups and countries. Its first study will be that of the extremely low rate of cancer of the cervix in Jewish women. Hospitals in Chicago, New York and Israel, and possibly others in Moslem Lebanon will co-operate.

* * *

People who refuse treatment for early cancer harbor the illusion that by waiting their cancer will cure itself.

* * *

Physicians giving inadequate cancer therapy merely waste their own time and the patient's opportunity for a cure.

* * *

When treating sarcoma of soft parts never "shell out" the tumor, but extend the incision well beyond the pseudocapsule.

* * *

In the past, pneumonia in elderly men was a common cause of death. Many of these so-called pneumonias were pneumonitis secondary to bronchiogenic cancer. Today, antibiotic therapy relieves the pneumonitis and the patient does not die from the inflammatory complications of lung cancer. Also, many cancers of the lung have had a previous diagnosis of virus pneumonia.

* * *

On the average, about ten months elapse after first symptoms of lung cancer and competent treatment. About half of this lost time is due to incorrect diagnosis by the first physician consulted. The other half is due to the patient's negligence.

*1. Borrus, J. C.: J.A.M.A. 157:18[illegible]ril 30, [illegible] 2. Selli[illegible] S.: J.A.M.A. 157:1594, April 30, 1955. 3. Lemere, F.: [illegible]thwest Med[illegible]098, Oct. [illegible]5. 4. Bene[illegible] B. and M[illegible]ocutti, C.: Lav. neuropsichiat. 18:693, 19[illegible] 5. Selli[illegible]G.: J. Clin[illegible] Exper. Psy[illegible]th. 17:7, [illegible]arch 1956. 6. Berglund, M., Blumenthal, B.[illegible]lordh, P.[illegible]nska läk. 53:3362, Dec. [illegible] 1956. 7.[illegible]el, H. A., Wood, J. A. and Dixon, H. H.: [illegible]ew York Aca[illegible]c. 67:780, May 9, 1957. [illegible]Hollister,[illegible]E., Elkins, H., Hiler, E. G. and St. Pierr[illegible]Ann. New Yo[illegible] Acad. Sc. 67:789, May 9, [illegible]57. 9. Ga[illegible]T.: Rass. med. 34:233, July-Aug[illegible]1957. 10[illegible]i, R. et al[illegible] J. Pediat. Praxis 20:27, [illegible]g. 1957.[illegible]iklund, P[illegible]: Anaesthesist[illegible]07, Aug[illegible]7. 12. Tucker, W. I.: Sout[illegible]M. J. 50:1111, Sept. 195[illegible]3. Rolandi[illegible]: Attual. ostet.[illegible] 3(6[illegible]9, Nov.-Dec. 1957. 14.[illegible]Checker, W.: Klin. Mona[illegible]l. Augenh[illegible]2):224, 1958.[illegible]nebianco[illegible]G. and Ceroni, T.: Oto-[illegible]ring. ital. 26(2):143, 1958. 16.[illegible]o, G.: Minerv[illegible]49:1914,[illegible]958. 17.[illegible]tuso, R. and[illegible]tti, F.: Ac[illegible]eurol. [illegible]3(1):36, J[illegible]1958. 18.[illegible] Gazz. med. ital. [illegible]49, Feb. 195[illegible]Pastur, R.[illegible]: J. Indian M. Prof[illegible]13, Feb. 1958.[illegible]st, W.: Therap. G[illegible]t 97:66, Fe[illegible]21. Be[illegible]P.: Lyon méd. 19[illegible] March 2, 1958.[illegible]miglia, G.: Miner[illegible] 10:218, M[illegible]15, 1958.[illegible]dlander, H. S.:[illegible] Cardiol. 1:395,[illegible]1958. 24. McCler[illegible]: Arch. Pe[illegible]75:101, M[illegible]25. Sprauer, V. J.[illegible] Internat. Rec. Med.[illegible]GP Clinics 171:[illegible]1958. 26.[illegible]inson, R.[illegible] Robinson, H. M.,[illegible]r.: South. M. J. 51:[illegible]9, April 1958. 27.[illegible], S. and Pe[illegible]er, L.: Ne[illegible]Med. 58:1285, April[illegible]15, 1958. 28. Bouquerel, J., Naviau and[illegible]ne: Ann. méd.[illegible]ychol. 116:[illegible]ne 1958. 29. Reboul, E., Reboul, M. and Dorgeuille, C.: Maroc[illegible]37:784, July 1958. 30. B[illegible]. Lyon méd. 200:885, Nov. 1958. 31. Lamphier, T. A.: Maryland M[illegible]7:627, Nov. 1958. 32. Leuke[illegible]Med. Klin. 53:2113, Dec. 1958.

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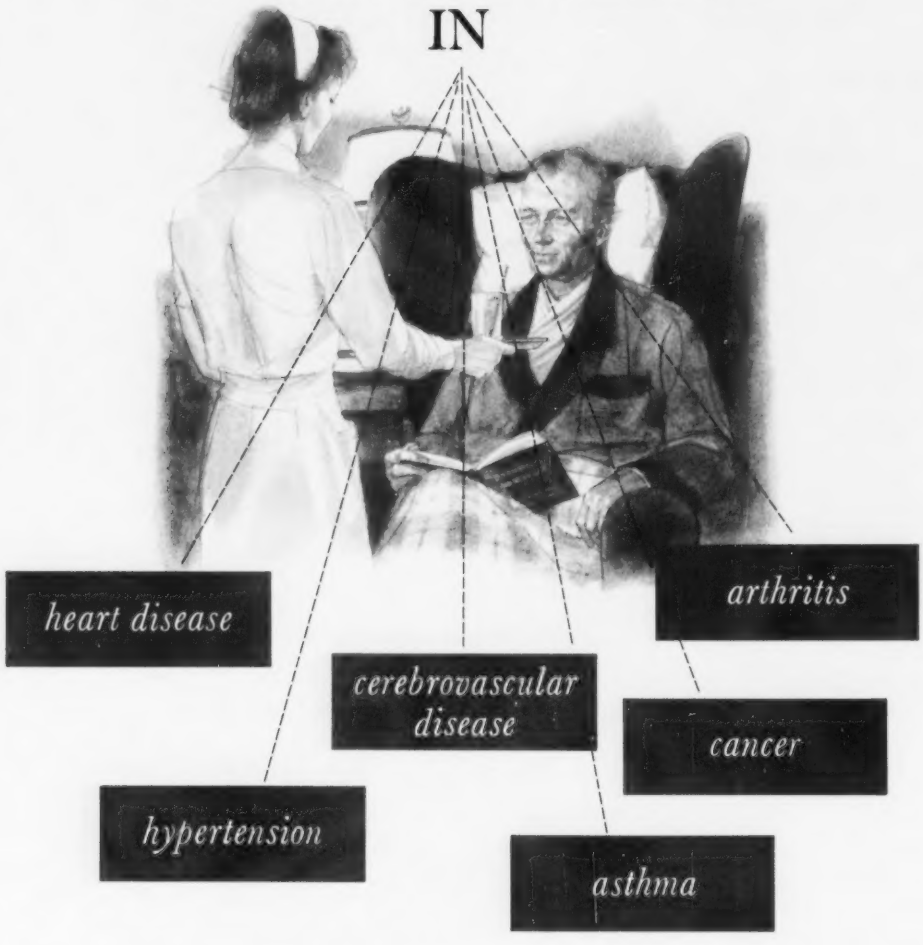
AIDS EMOTIONAL ADJUSTMENT TO CHRONIC ILLNESS IN



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Miltown is well tolerated and *"therefore well suited for prolonged treatment in chronic disorders with emotional complications."* (Friedlander, H. S.: Am. J. Cardiol. *1*:395, March 1958.)

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meprobamate (Wallace)

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You and Your Business

HIGHLIGHTS OF THE EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of April 1, 1959

- **Recommendations of AMA Commission on Medical Care Plans.**—Presented were the opinions of component societies on the two questions in the AMA Commission's report: 1. Is free choice of physician essential to good medical care without qualification?; 2. What will be your attitude to physician participation in systems of medical care that restrict free choice?

  The whole report was discussed by AMA Delegates' Chairman Wm. A. Hyland, M.D., Grand Rapids, who pointed out that the AMA Committee had studied these questions for two years, that the AMA House of Delegates and Board of Trustees must assume responsibility for adopting or disapproving the report, and that the delegates would consider this in Atlantic City in June, 1959. The Executive Committee of The Council took action to notify the AMA that it is in sympathy with the report of the Commission, as a whole.

- **Veterans Administration Home Town Medical Care Program.**—Further negotiations on this program definitely indicates that the Veterans Administration desires to run this program direct and without intermediaries (Michigan Medical Service as agent of the medical profession of Michigan). The negotiators for the State Society were instructed to take a firm stand in negotiations with the Veterans Administration.

- **MSMS Group Life Plan**—President-Elect Milton A. Darling, M.D., Detroit, reported that the MSMS Plan had been approved by the State Insurance Commissioner and that to date, a total of 907 members had requested coverage; certificates will be mailed this month.

- **The Executive Committee of The Council** referred to the Committee on Constitution and Bylaws a recommendation that Chapter 4, Section 4 of Bylaws be changed to include the word "death" as well as "resignation" as a reason for refund of State dues for the unexpired portion of the year.

- **Governor's Citizen Mental Health Inquiry Board.**—Grover C. Penberthy, M.D., Detroit, a member of this Board, requested approval of certain doctors of medicine to visit State mental hospitals in their respective areas and study methods used in reporting anything unusual that might occur such as accidents and injuries either self inflicted, caused by an inmate or by any other individual. The Executive Committee of The Council recommended the following doctors: Vernon C. Abbott, M.D., Pontiac; Kneale M. Brownson, M.D., Traverse City; Darrell A. Campbell, M.D., Ann Arbor; James H. Fyvie, M.D., Manistique; Harold J. Meier, M.D., Coldwater; Matthew Peelen, M.D., Kalamazoo; Robert E. Rice, M.D., Greenville; and Harry B. Zemmer, M.D., Lapeer.

- **President G. B. Saltonstall, M.D.,** was authorized to represent the Michigan State Medical Society at the annual meeting of the Medical Society of the State of Wisconsin in Milwaukee, May 5-6; President-Elect M. A. Darling, M.D., was authorized to represent MSMS at the dedication of the new State Bar of Michigan building, May 1, in Lansing; Doctor Darling also will represent MSMS at the Michigan State Rural Health Conference, East Lansing, April 9, and will present a talk to the Senior Medical Students at the University of Michigan, April 15 on "The Roll of the Michigan State Medical Society."

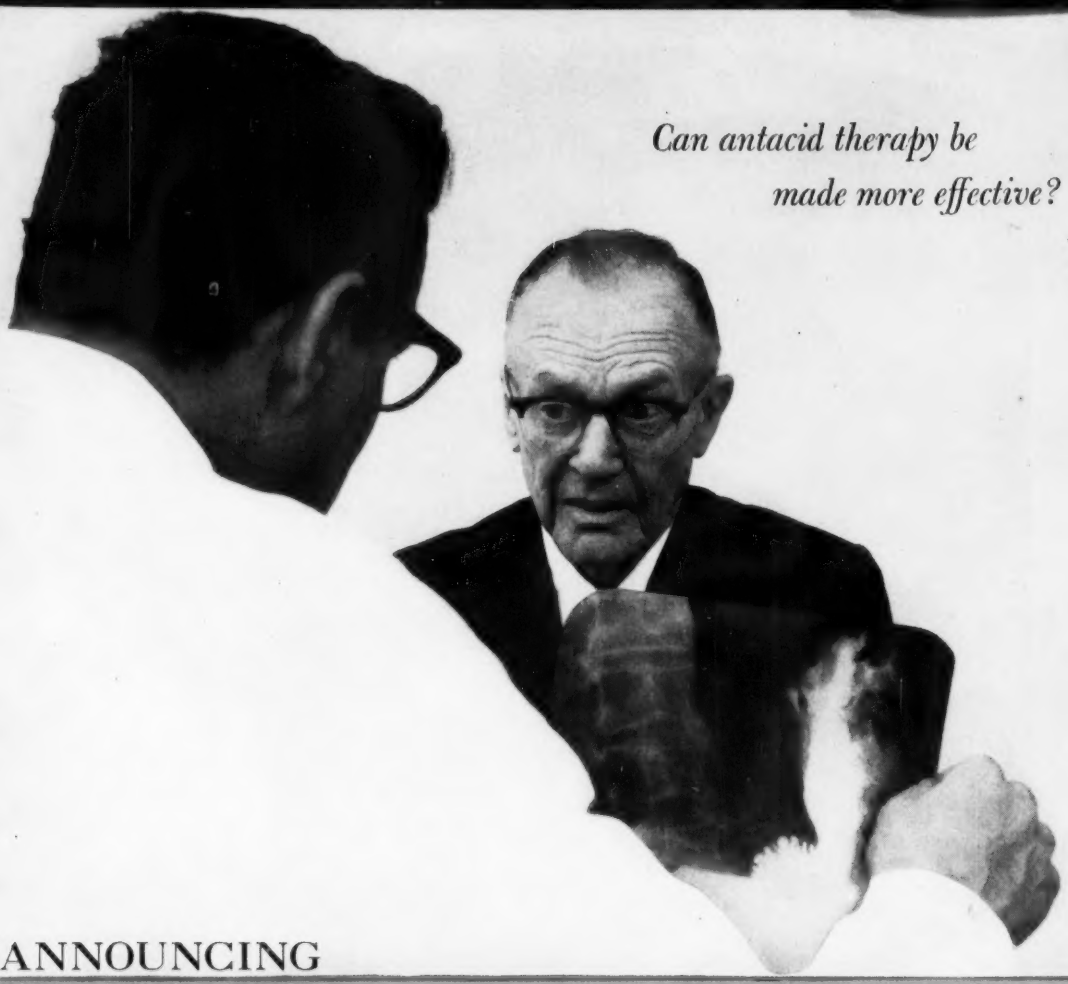
- **The following official representatives** of the Michigan State Medical Society will act as ubiquitous hosts to six of the Annual Session public speakers in Grand Rapids, September 29, 30-October 1, 2, 1959: Clarence F. Webb, M.D., Grand Rapids, for guest speaker Isador Dyer, M.D., of New Orleans; R. I. Seime, M.D., Grand Rapids, for guest speaker Ivan H. Smith, M.D., of London, Ontario; R. H. Gilbert, M.D., Grand Rapids, for guest speaker Lorand V. Johnson, M.D., Cleveland; W. T. Cruse, Jr., M.D., Grand Rapids, for guest speaker Harvey Blank, M.D., Miami; J. C. Montgomery, M.D., Grand Rapids, for guest speaker James G. Hughes, M.D., Memphis; C. Allen Payne, M.D., Grand Rapids, for guest speaker F. G. Germuth, Jr., M.D., of Charlotte, N. C.

  Additional ubiquitous hosts will be appointed to officially represent the Michigan State Medical Society in entertaining all the guest essayists.

- **Personnel of the Committee on Arrangements** for the 1960 Michigan Clinical Institute was selected, with R. J. Hubbell, M.D., Kalamazoo, as General Chairman and Wm. S. Reveno, M.D., Detroit, as Chairman of Program and Television Committees. Press Committee was appointed: A. B. Gwinn, M.D., Hastings, Chairman; H. F. Dibble, M.D., Detroit; R. W. Shook, M.D., Kalamazoo; Milton R. Weed, M.D., Detroit; and C. L. Weston, M.D., Owosso.

- **Referred to the Committee on Constitution and Bylaws** was the AMA recommendation that *active* membership be provided for M.Ds. in the Armed Forces, Public Health Service, and Vet-

(Continued on Page 894)



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1. *Neutralizes acid faster (quicker relief)*
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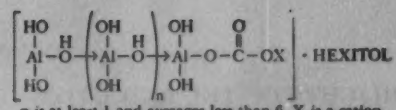

n is at least 1 and averages less than 6. X is a cation.

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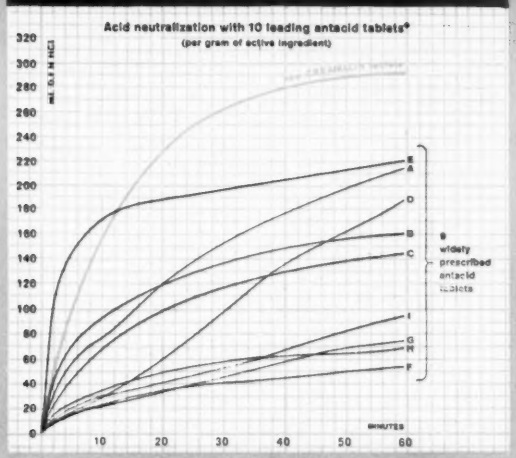

Tablets were powdered and suspended in distilled water in a constant temperature container (37° C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour

CREAMALIN neutralizes *more* acid *longer*

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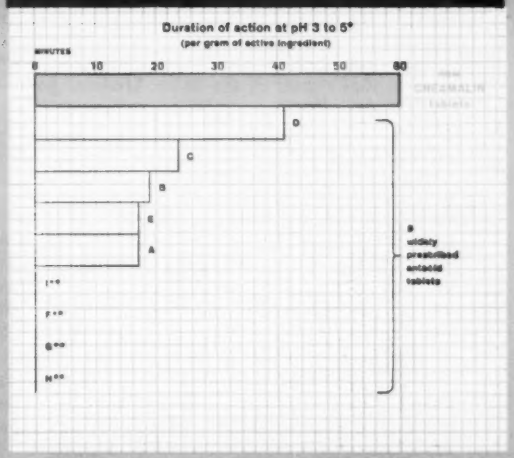

*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
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No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

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Supplied: Bottles of 50, 100, 200 and 1000.

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HIGHLIGHTS OF THE EXECUTIVE COMMITTEE OF THE COUNCIL

(Continued from Page 890)

erans Administration, in order that these doctors may be qualified for *active* membership in the AMA.

- **Official MSMS representatives** to the Upper Penninsula Medical Society meeting, June 19-20, 1959, were authorized.

- **The annual report of the State Medical Journal Advertising Bureau,** which acts as agent for JMSMS in procurement of advertising, was reviewed by Editor Wilfrid Haughey, M.D., Battle Creek, and received by the Executive Committee.

- **Public Relations Counsel's report** included report on resolution from Bay-Arenac-Iosco County Medical Society favoring state sales tax; correspondence from Congressman Charles E. Chamberlain reporting that his recent survey of the sixth Michigan district voters disclosed that 52 per cent opposed, 36 per cent favored, and 12 per cent were uncertain re extension of social security in the area of medical care; progress report on Michigan Association of the Professions indicated 779 members as of April 1, 1959.

- **J. J. Lightbody, M.D.,** Detroit, reported preliminary estimates on cost of enlarging MSMS Public Relations office in new David Whitney House (Wayne County Medical Society Headquarters) Detroit.

- **Committee reports**—The following were considered: 1. Diabetes Committee, meeting of March 10; 2. Medical Care Insurance Committee, meeting of March 18; 3. Legislative Committee, March 19.

- **Central Cancer Registry.**—Announcement was made that a new central cancer registry is being developed by the Michigan Cancer Coordinating Committee—the details to be presented to the Executive Committee of The Council at its May 20 meeting.

- **Appointments.**—(a) To Michigan Hospital Medical Advisory Committee: Frank J. Busch, M.D., Saginaw, and Ralph W. Shook, M.D., Kalamazoo. (b) To Michigan Joint Council to Improve Health Care of the Aged (to serve with representatives of the Michigan Hospital Association, Michigan State Dental Association, and the Michigan Nursing Home Association): Frederick C. Swartz, M.D., Lansing, Chairman; A. H. Hirschfeld, M.D., Detroit, and A. Hazen Price, M.D., Detroit. (c) To National Leadership Training Institute White House Conference on Aging, Ann Arbor, June 24-26: Frederick C. Swartz, M.D., Lansing; A. H. Hirschfeld, M.D., Detroit; A. Hazen Price, M.D., Detroit, and C. Howard Ross, M.D., Ann Arbor

- **Changes.**—(a) H. B. Latourette, M.D., Ann Arbor, resigned from Committee on National Defense as he is moving to Iowa. Thanks were extended to Doctor Latourette for his splendid past service, with best wishes for success in his new work. (b) Resolution to the late N. A. Fleishmann, M.D., President of Muskegon County Medical Society at the time of his death, was adopted and spread upon the Executive Committee minutes.

- **Michigan Health Commissioner A. E. Heustis, M.D.,** reported on tuberculosis case findings procedure in northern Michigan; increases in diagnostic laboratory tests; bacteriophage action; poliomyelitis progress report; hospital certification and maternity hospital licensing; and x-ray protection.

- **Ground Breaking Ceremony.**—The Executive Committee called a special meeting at the new site of the State Society (Saginaw Street and Abbott Road in East Lansing) for 4:30 p.m. this date, as part of the ground breaking ceremony.

MEDICAL MEETINGS AND CLINIC DAYS

1959		
June 19-20	Upper Peninsula Medical Society	Gateway Hotel Land O'Lakes, Wisc.
June 25	Keyport Trauma Day—American College of Surgeons	Hidden Valley Lodge Gaylord
July 30-31	Coller-Penberthy Clinic	Traverse City
Sept.29-30 Oct. 1-2	Michigan State Medical Society Annual Session	Pantlind Hotel Grand Rapids

AMA Washington Letter

THE MONTH IN WASHINGTON

Congress won the first round in a battle over medical research funds, but the Eisenhower Administration is in a strategic position for the final outcome.

The House voted $344,279,000 for the National Institutes of Health, $50 million more than the Administration asked for in the fiscal 1960 budget. The move to increase medical research funds also had strong support in the Senate.

However, the Health, Education and Welfare Department and the Budget Bureau will have the final say on how much of the appropriated funds are spent during the 1960 fiscal year when the Administration is striving to balance the budget.

Arthur S. Flemming, Secretary of Health, Education and Welfare, vigorously denied a charge of the Democratic-controlled House Appropriations Committee that the Administration had "gone so far as to set back the medical research program . . . in a desperate attempt to present, on paper, a balanced budget." Flemming said the committee was trying to give a "clearly misleading" impression. He also said it was hard to see how the Administration's $294 million program could be regarded as a backward step.

Flemming pointed out that the Administration request was for the same amount voted by Congress last year. And, he added, some of last year's appropriation will not be spent this fiscal year.

At the same time, U. S. Surgeon General Leroy E. Burney testified before a Senate Appropriations Subcommittee that there was a shortage of trained personnel in all fields related to human health, including medical research.

Rep. Francis E. Dorn (R., N. Y.) again has introduced a bill that would provide for a special commission making a study of the supply of physicians. In a letter put in the *Congressional Record,* Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association, envisaged an adequate supply on a long-range basis. He said: "Over the long haul, the increase in medical students is much greater proportionately than is the increase in the population. . . . The future, I believe, looks bright."

* * *

A government-sponsored, six-year study of the causes of cerebral palsy, mental retardation and kindred defects in children has gotten underway in 16 private hospitals and universities.

The study involves no experimentation, only observation. About 40,000 women will be kept under close check from the second or third month of pregnancy through childbirth. Observation of their children will be maintained through six years of age.

* * *

U. S. scientists have blamed Russia for most of the radioactive fall-out thrust into the atmosphere in the last two years. But testimony before a Joint Congressional Committee on Atomic Energy estimated that overall the United States and Great Britain had created nearly three times as much radioactive debris by testing nuclear weapons as the Soviet Union had.

Russian tests were described as "extremely dirty" as to radioactive debris. However, the Russians have not exploded as many test weapons and devices as the Western Powers have.

The scientists differed on the degree of danger to humans posed by the radioactive fall-out. John A. McCone, Chairman of the Atomic Energy Commission, said that up to now the fall-out hazard has been "very small" and not serious when compared with common hazards, including natural radiation. But he warned against a "very serious hazard" in the future if nuclear tests are not restricted by international agreement.

* * *

The Walter Reed U. S. Army General Hospital in Northwest Washington quietly marked its fiftieth anniversary recently. Its 448,000 patients since it was founded in 1909 have included presidents, congressmen, cabinet members and other notables. President Eisenhower underwent an ileitis operation there in 1956. Gen. John J. Pershing died there in 1948 after being a patient for seven years. The two most distinguished patients recently: former Secretaries of State John Foster Dulles and George C. Marshall.

* * *

A Food and Drug Administration official has urged that physicians use care and judgment in writing PRN and similar prescriptions for sleeping pills and amphetamines. Nevis Cook of the agency's enforcement bureau said some pharmacists have been selling the drugs too freely on such prescriptions. The FDA planned to take court action when a glaring abuse presented a strong case. The issue is whether a pharmacist improperly practices medicine by indiscriminately refilling such prescriptions.

To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field*.† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF. — METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

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OTIC DROPS: Bottles of 5 cc. with sterile dropper.

OINTMENT: Tubes of ½ and 1 oz. and tubes of ⅛ oz. with ophthalmic tip.

OPHTHALMIC SOLUTION: Bottles of 10 cc. with sterile dropper.

NEW { **LOTION:** Plastic squeeze bottles of 20 cc.
NEW { **POWDER:** Shaker-top bottles of 10 Gm.

OINTMENT: Tubes of ½ oz., 1 oz. and ⅛ oz. (ophthalmic tip).

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with low incidence of sensitivity reactions... Extremely low in toxic potential. [2, 3] No cutaneous or other objective reactions seen in a wide scale study of clinical toxicity. [2] Even minor subjective reactions are not expected to occur [2] or are reported absent [3] when recommended schedule is used.

TABLETS, 0.5 Gm., bottles of 24 and 100. New ACETYL PEDIATRIC SUSPENSION, cherry flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.), bottles of 4 and 16 fl. oz.

1. Editorial: New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med. & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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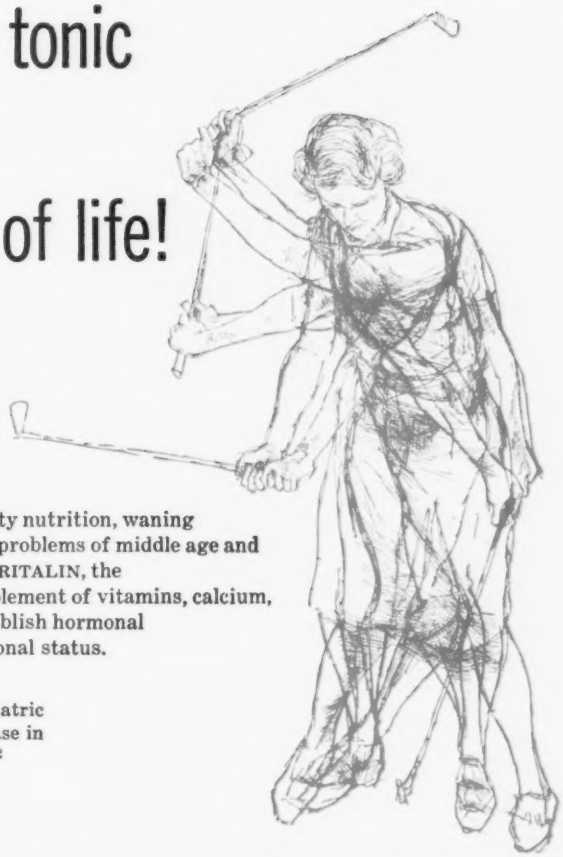

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"We found Ritonic to be a safe, effective geriatric supplement . . ."[1] "Patients reported an increase in alertness, vitality and sense of well being."[2]

PRESCRIBE RITONIC

for your geriatric patients, your middle-aged patients and your postmenopausal patients.

Each Ritonic Capsule contains:

Ritalin® hydrochloride	5 mg.
methyltestosterone	1.25 mg.
ethinyl estradiol	5 micrograms
thiamin (vitamin B_1)	5 mg.
riboflavin (vitamin B_2)	1 mg.
pyridoxin (vitamin B_6)	2 mg.
vitamin B_{12} activity	2 micrograms
nicotinamide	25 mg.
dicalcium phosphate	250 mg.

Dosage: One Ritonic Capsule in mid-morning and one in mid-afternoon.
Supplied: Ritonic CAPSULES; bottles of 100.
References: 1. Natenshon, A. L.: J. Am. Geriatrics Soc. *6*: 534 (July) 1958.
2. Bachrach, S.: To be published.
RITALIN® hydrochloride (methylphenidate hydrochloride CIBA)

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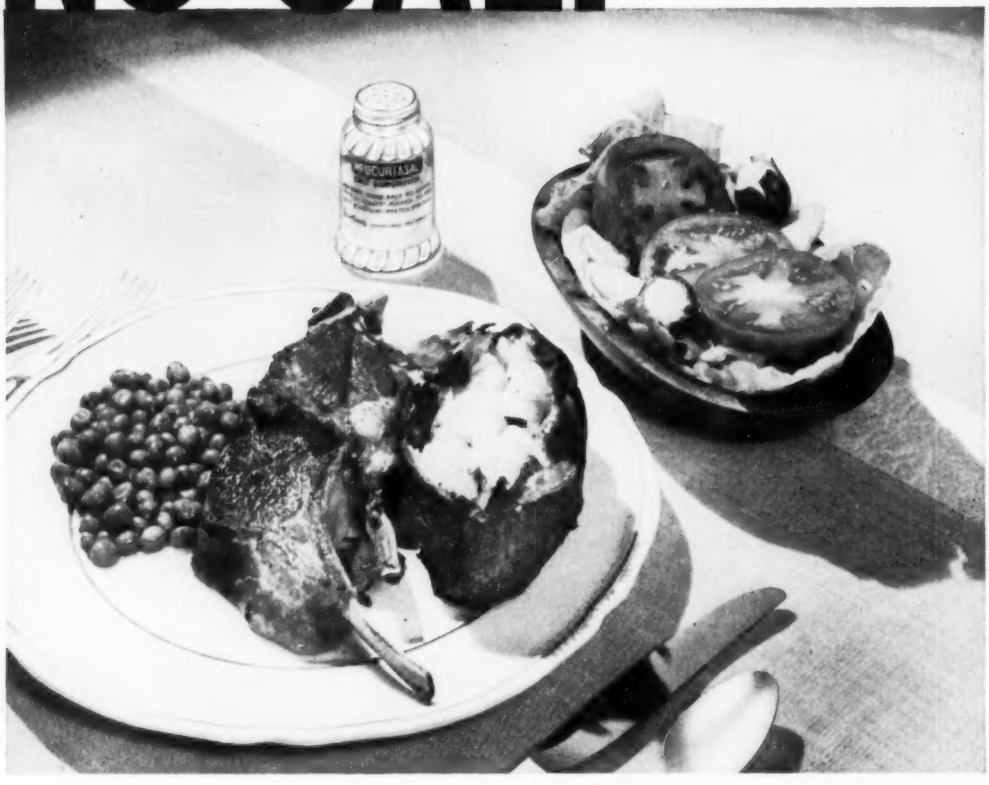

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2 oz. shakers and 8 oz. bottles

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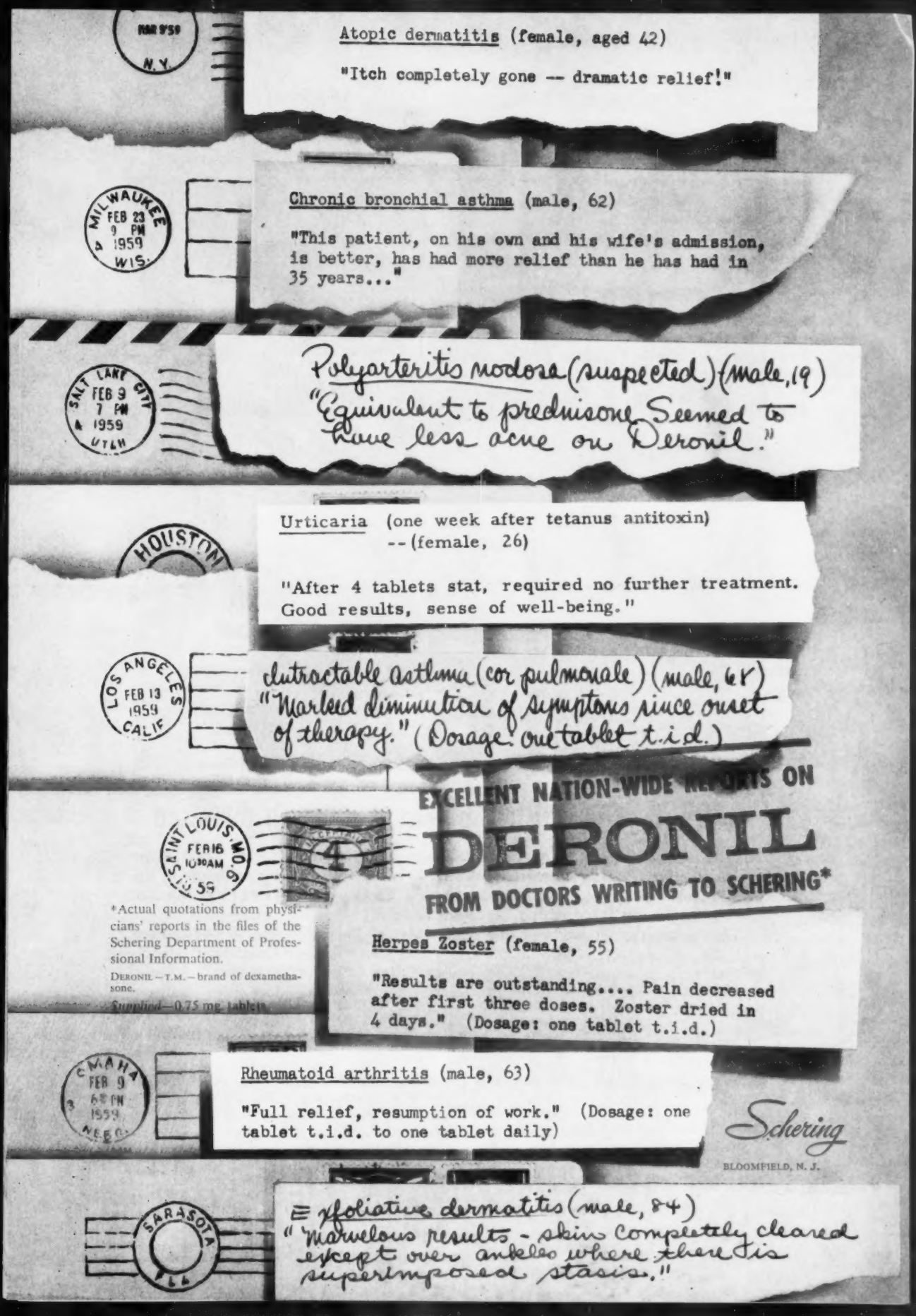
Atopic dermatitis (female, aged 42)
"Itch completely gone -- dramatic relief!"
Chronic bronchial asthma (male, 62)
"This patient, on his own and his wife's admission, is better, has had more relief than he has had in 35 years..."
Polyarteritis nodosa (suspected) (male, 19)
"Equivalent to prednisone. Seemed to have less acne on Deronil."
Urticaria (one week after tetanus antitoxin) -- (female, 26)
"After 4 tablets stat, required no further treatment. Good results, sense of well-being."
Intractable asthma (cor pulmonale) (male, 68)
"Marked diminution of symptoms since onset of therapy." (Dosage: one tablet t.i.d.)
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FROM DOCTORS WRITING TO SCHERING*
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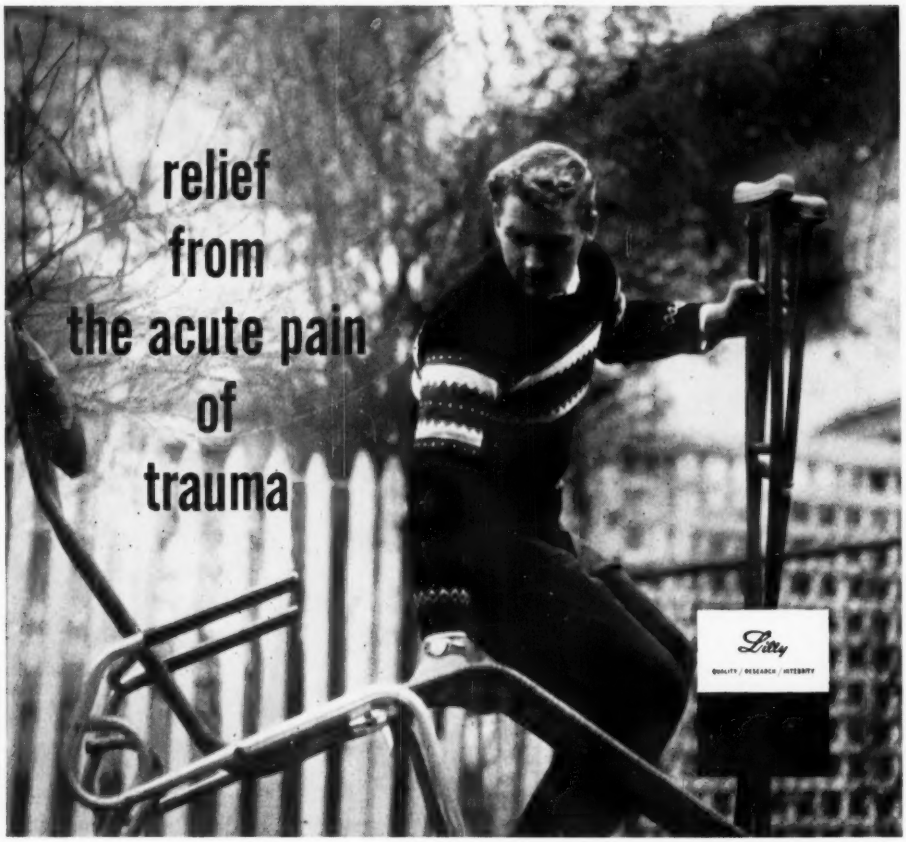
Supplied—0.75 mg. tablets.
Herpes Zoster (female, 55)
"Results are outstanding.... Pain decreased after first three doses. Zoster dried in 4 days." (Dosage: one tablet t.i.d.)
Rheumatoid arthritis (male, 63)
"Full relief, resumption of work." (Dosage: one tablet t.i.d. to one tablet daily)
Schering
BLOOMFIELD, N. J.
Exfoliative dermatitis (male, 84)
"Marvelous results - skin completely cleared except over ankles where there is superimposed stasis."



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Usual dosage: 32 mg. (approximately 1/2 grain) every four hours or 65 mg. (1 grain) every six hours.

Darvon® Compound (dextro propoxyphene and acetylsalicylic acid compound, Lilly)

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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of The Council

VOLUME 58 JUNE, 1959 NUMBER 6

New Drugs for Old Uses and New Uses for Old Drugs

By Fredrick F. Yonkman, M.D.
Madison, New Jersey

PROGRESS in drug therapy during the last two decades supersedes that of all time prior to 1935. The Health News Institute* recently stated:

For thousands of years man has used herbs and plant products to help himself when he is ill. In the past hundred years, with the development of the biological sciences and the advent of synthetic organic chemistry, his progress has been greater than at any time in recorded history. In the past twenty years, an almost complete chemical revolution in medicine has taken place.

The golden age of pharmaceutical research may be said to have begun about fifty years ago with the work of Paul Ehrlich, the German bacteriologist, whose careful testing of hundreds of arsenic compounds led to the development of compound 606, Salvarsan, for the treatment of syphilis. In the following decades came new barbiturates for inducing sleep, modern germicides, intravenous anesthetics and the sulfa drugs. In this period, insulin, sex hormones and vitamins were isolated and made available to medicine. In the late 1930's developments gathered real momentum.

This most recent progress is obvious to all of us from our use of sulfas, antibiotics, antihistamines, corticosteroids, antihypertensives, tuberculocides, tranquilizers, diuretics, et cetera. We should not, however lose sight of those old friends of ours, amyl nitrite, aminopyrine, nikethamide, alcohol and others, as they become newly applicable in some of our long-standing medical problems such as biliary "colic," acute alcoholism or Parkinsonism. Good therapeutic judgment crystallizes from examination of new drugs in the mirror of the past. New drugs are very important for old uses but often, just as important, are new uses for old drugs.

Anyone interested in this rapid progress in the

THE PROGRESS OF THERAPY

1910	1945
1. Ether	1. Penicillin, Sulfonamides, Antibiotics
2. Morphine	2. Whole blood, blood plasma, blood derivatives
3. Digitalis	3. Quinine, quinacrine
4. Diphtheria antitoxin	4. Ether, other anesthetics, morphine, cocaine and barbiturates
5. Smallpox vaccine	5. Digitalis
6. Iron	6. Arsphenamines
7. Quinine	7. Immunizing agents and specific antitoxins and vaccines
8. Iodine	8. Insulin and liver extract
9. Alcohol	9. Other hormones
10. Mercury	10. Vitamins

Presented at the Twelfth Annual Fall Postgraduate Clinic of the Michigan Academy of General Practice, Detroit, Michigan, November 13, 1958.

development of new and better therapeutic agents, either for specific treatment or symptomatic relief, must be impressed by the enlightening presentation which appeared in the *Journal of the American Medical Association*, March 10, 1945. A condensation of these data is shown in the preceding table.

One notes not only the great change for the better in the column on the right compared to that on the left, but also how some of our old-timers, depended upon in 1910, are still able assistants thirty-five years later, even though their relative position of importance has been altered due to the dramatic introduction of specific therapeutic agents for most types of infections plaguing mankind.

Still later and more dramatic strides have been made in the progress of therapy in the last ten or twelve years as is evident from a review of the following list:

PROGRESS SINCE 1945

Newer antibiotics, Cortisone modifications
Drugs for treatment of:
Tuberculosis, Motion sickness
High blood pressure, Cancer
Mental illness, Anxiety
tension, Lethargy
Arteriosclerosis (?)

Where would we be today without these new therapeutic agents? What little might have materialized if you and I and hosts of others were not interested in mutual co-operation through research developments and clinical collaboration at the bedside to improve the health and welfare of our fellow beings? Small wonder then that Dr. Theodore Klumpp, President of Winthrop Laboratories, so rightly states:[18]

> . . . In the last fifty years more progress has been made in the conquest of disease and the prolongation of life than had been accomplished in the entire 999 centuries of man's previous existence on earth. With faith in ourselves, the men and women of tomorrow can look forward to accomplishments in the next fifty years that will dwarf those of the past half century.

Today, an average of 1,200,000 prescriptions are written, 90 per cent of which could not have been filled ten years ago!

This discussion must necessarily be limited to a very few items which I think are of unusual interest and importance.

One of our great intruders and enemies is pain and in our efforts to offer relief from this affliction through analgetics, we have come a long way from morphine and its synthetic substitutes to that most recent excellent preparation Darvon or Darvon compound.

The Lilly organization should be congratulated for having made a real contribution to this area of therapy. Darvon and Darvon compound give relief in many types of pain including that associated with trauma of the periosteum.[14,15] It is effective by mouth, indicating that it is well absorbed. Thus far, there has been no evidence of addicting properties after two years of use, and it is hoped that it may not develop addiction in man even after prolonged use. Thus far, there also have been no evidences of hematologic changes of any concern nor of undesirable smooth muscle contraction of the gastrointestinal tract, specifically of the duodenum as has been so well established for morphine and several of its synthetic substitutes.

In the treatment of pain let us not forget our old friend, aspirin—buffered or otherwise—for, as you have noted, it is included in all APC mixtures which may even contain an additional specifically-acting analgetic, antihistaminic, or vasoconstrictor, for example, for the relief of coryza. Even aminopyrine (N.F.) the oldest, non-narcotic, is receiving a "new look." It is not coming back to haunt us unjustifiably but rather to use intelligently even as an antipyretic in severe infections as reported by Cardon and associates[3] of Northwestern University Medical School. It is still one of the most valuable anodynes and antipyretics in our therapeutic armamentarium despite its almost complete abandonment as a result of a full report by Kracke[19] in 1935.

Aminopyrine, in one form or another, and often when combined with a mild sedative such as a small dose of barbiturate, stands uppermost on many lists of anodynes in Europe, South America and the Far East. It seems to be less offensive in producing agranulocytosis than some of our new, widely used, synthetic drugs developed in the last ten or twenty years; this statement would seem to have firm foundation by the very extensive use of aminopyrine as cited above in most countries outside the United States. It is my understanding that in Brazil, for example, aminopyrine can be purchased over-the-counter ad libitum. The relative safety of this drug thus would seem to be reasonably well assured and it behooves us to take a second look at some of our old stand-bys that are tried and true pain relievers and antipyretics for such common afflictions as migraine headaches

and dysmenorrhea, in particular, as well as in fevers due to infections. Such frequent reinspection would seem preferable to the constant search for new drugs for old uses, desirable as this may be for certain indications.

In order to bring aminopyrine into proper focus regarding its pros and cons, the following statements by Cardon and his associates are valuable:[3]

> Modern medical science has made such tremendous strides in the field of therapeutics that many older drugs, especially if potentially productive of untoward and dangerous side-effects, have been discredited and have fallen into disuse. Admittedly, many such drugs have marked therapeutic value and are deserving of further investigation and clinical trial before they are completely discarded.
>
> Aminopyrine, by force of historical circumstances, has been such a discredited drug for many years. Its value as a potent antipyretic is well known and needs no extensive elaboration.
>
> Aminopyrine is still a uniquely valuable and occasionally life-saving antipyretic which deserves a trial whenever fever is a significant feature of the clinical picture of disease. It may be effective under conditions in which other antipyretics and even the most powerful and specific of the newer drugs fail. The danger of agranulocytosis from its use, although real, has been overemphasized and is no greater than with many other drugs in common use today. Aminopyrine has its place in therapeutics under well controlled clinical conditions and under the supervision of a physician, but its careless and indiscriminate use is to be condemned.

The second look at any drug is certainly further justifiable as manifest today by the increasing return of Chloromycetin and sulfa drugs in certain infections.

In reference to pain associated with biliary spasm or biliary colic, I should like once again to draw attention to our good old friends, amyl nitrite and spirit of nitroglycerin. Nitrites, especially amyl nitrite and nitroglycerin, have long been an important group of drugs, but rebirth of their gastrointestinal potentialities has been due to the fine work of McGowan and his co-workers.[20] Years ago, biliary spasm was relieved by inhalation of amyl nitrite but, as is so typical of therapeutic procedures, each has its day, its peak and dip until therapy becomes rational as proven by objective physiologic research. With small balloons in the common duct of available patients, made accessible by way of drainage T-tubes following surgical intervention, such as cholecystectomy or cholecystotomy, McGowan graphically demonstrated the relaxing effect of nitrites even after the smooth muscle of the common bile duct had been rendered painfully spastic by morphine. Morphine tends to increase smooth muscle tone throughout the entire intestine[26] as well as in the common duct. Demerol does likewise in the duodenum as demonstrated by Gaensler and his associates.[10]

Hence, quick relief under amyl nitrite results from relaxation of all smooth muscle, including the spastic sphincter of Oddi, allowing dammed back bile to "flush" the common duct exit into the duodenum, probably carrying with it any small obstructing substance at the orifice. Continued relief may necessitate sustained relaxation by the supportive use of nitroglycerin, many patients requiring no morphine if the nitrites are judiciously employed. Nitroglycerin can be administered in dosage of one one-hundredth of a grain (0.0006 gm.), and relief usually follows in from five to ten minutes, enduring for an hour or more and, on occasion, indefinitely. Dramatic relief has been obtained with this therapy in many hands and our limited experience supports the frequently enthusiastic claims associated with this very rational type of treatment. As important as are new, specifically-acting drugs, proper usage of older agents is extremely gratifying when physiologic disturbances can often be so easily altered if one knows the cardinal action of these commonly used, time-tested agents.

Penicillin is both new and old, relatively new as a chemotherapeutic agent, but old as the first antibiotic to be extensively used. As Zimmerman[27] states:

> Penicillin was the first, and is still the most extensively used antibiotic. Three hundred and fifty tons of penicillin a year are currently produced in the United States. This is 500 trillion units, over 3 million units per inhabitant.[13] Penicillin is relatively inexpensive and still the treatment of choice for many infections susceptible to antibiotic therapy. However, allergic reactions to penicillin have become increasingly more common. Between 5 and 10 per cent of the unselected population is now allergic to penicillin, and it causes over 80 per cent of all drug eruptions. With the advent of benzathine and other repository penicillins, reactions have become even more long-lasting and violent. Most physicians have seen severe penicillin reactions, which refused to respond to any conventional anti-allergic therapy. A dread of such reactions and of medico-legal sequels, has made physicians withhold penicillin, even when it was the antibiotic of choice.
>
> Allergic reactions to all types of penicillin, and to all routes of administration, have been reported. Substitution (i.e., O for G or oral for injectable) is seldom

of value. Antihistamines, given concurrently with penicillin, may inhibit an immediate anaphylactic reaction, but mask valuable warning signals, with anaphylaxis impending when the antihistamine effect wears off. Penicillin reactions are less frequent and less severe in children than in adults, but any type of reaction may appear in any individual. Skin testing is not of sufficient value to warrant routine use. *Severe and even fatal reactions may occur after negative skin testing.*

History is more reliable than skin testing. If the patient has had a reaction to penicillin, he will probably react on re-exposure more violently and more rapidly. Malpractice suits have been won by patients against physicians who gave them penicillin with knowledge of the patient's allergy to the drug. Unless the need for penicillin is specific and imperative, some other antibiotic should be used if the patient states that he has had a previous reaction to penicillin.

Once a full-blown penicillin reaction occurs the drug of choice is penicillinase.* This enzyme is not only dramatically life-saving in such an emergency but also it rapidly ameliorates the severe symptoms associated with the penicillin reaction. Here, attention should be directed to Minno and Davis[22] for their fine gesture of giving credit to Becker[2] who first suggested the use of penicillinase (discovered by Abraham and Chain[1]) for penicillin reactions. This is another fine illustration of therapeutic application of a basic laboratory principle; "therapeutic discoveries" are really not such, they are "developments," often based on observations[25] made by the laboratorian interested in basic research.

One must remember that while the remarkable benefits of penicillinase are due to its capacity to completely inactivate penicillin as an allergen, it also destroys its therapeutic or antibiotic powers. Therefore, other antibiotics or chemotherapeutic agents must obviously be employed if the clinical indications of infection still warrant such alternative therapy.

Another problem of growing importance is that of acute and chronic alcoholism. In the former, "sobering off" or "drying out" is not only time-consuming but often an obnoxious and distasteful ordeal for the attendants. Glucose and insulin, as advised by Goldfarb and his co-workers[12] is of some assistance in increasing the metabolism or burning up of alcohol, but it is still a time-consuming procedure. Thus recent work with methylphenidate,**[7,11] a psychic stimulant employed generally and also in geriatrics,[23] is of special interest. Gale[11] of Mount Sinai Hospital in Cleveland brought to our attention his successful treatment of a child, age three and one-half, who had unfortunately become heavily intoxicated and comatose after ingesting an unknown quantity of whiskey. After two successive doses of 10 mg. of Ritalin (intramuscularly) about three hours apart, this patient recovered and was discharged about one-half hour after the second dose.

The average dead drunk adult is usually revived quickly to the point where he is alert, lucid and able to proceed home on his own power within fifteen to thirty minutes after the intravenous injection of this safe restorative. For example, Scogin and his associates[24] of Baylor University report very briefly on respective case histories as follows:

J. B.—male—chronic alcoholic brought in after passing out, unable to stand, very lethargic—50 mg. Ritalin i.v., three minutes later patient alert, awake—thirty minutes walked out and caught bus. Thus able to give immediate disposition to an otherwise twenty-four-hour problem.

Twenty-five mg. Ritalin i.v., acute intoxication, dramatic response, able to ambulate and converse in a few minutes.

J. P.—semi-conscious due to barbiturate overdosage—responds only to painful stimuli and not well to that. Ritalin 40 mg. i.v.—patient awake and alert in two minutes—able to go home.

Similar favorable results with this new drug have been reported[4] recently from Johns Hopkins Hospital but with the addition of old-fashioned nikethamide† intravenously, an addition which seems to prolong the effect of the stimulating restorative. If such reports can be adequately confirmed in the future by various clinics across the country, an old-fashioned drug may assist the new one in a long-standing affliction which is becoming daily a greater problem for all of us—acute and chronic alcoholism. Likewise, this restorative procedure becomes important in the rapidly growing problem of overdosage of sleeping tablets and tranquilizers. In both of these situations, injections of the restorative stimulant, Ritalin, is often almost as dramatic as in acute alcoholism.

In the event that Levophed* (norepinephrine) and Ritalin be used together to raise blood pressure and to stimulate respiration, extreme caution must be exercised on the basis of recent reports

*Neutrapen produced by SchenLabs Pharmaceuticals, Inc.

**Ritalin.

†Coramine.

*Winthrop Laboratories.

by Ivey[17] and Maxwell and his associates[21] for the former drug is markedly potentiated in its vasoconstrictive and hypertensive activity by the latter. On the other hand, this mutual relationship can likewise be employed to advantage should Levophed seem to become gradually less effective in certain patients in "shock" who require urgent treatment.

The relatively new use for the old-fashioned drug, alcohol, has been reported by numerous investigators following the pioneer work of Cooper[5] of St. Barnabas Hospital in New York City. The old problem of Parkinsonism, as we all know, can often be most disturbing and disconcerting despite medical therapy. Although several synthetic drugs have offered varying degrees of improvement over the old belladonna therapy, they still lack complete effectiveness while producing significant side reactions in some cases on increased dosage. Therefore the fine work of Cooper and his associates is all the more important. Proper targeting of small injections of alcohol (more recently in ethylcellulose (Etopalin)), in the globus pallidus, has often produced dramatic improvement in severe Parkinsonian patients. Not only rigidity but also tremor have been largely negated in 50 to 70 per cent of the patients thus treated.

Similar dramatic improvement has been reported by Cooper and his co-workers[6] in choreoathetosis or dystonia. The results thus achieved in both conditions are better appreciated when one is privileged to see the Kodachrome movies of patients before and after such alcoholic injection. To be sure, this is no child's play—this type of surgical intervention—and is to be restricted to only those hands of expert neurosurgeons, but it is comforting for us and the patient to know that mild to marked degrees of relief may be forthcoming in these long-suffering patients provided they be willing to take the relatively low degree of risk associated with this procedure. Again, a relatively new use for an old-fashioned drug, alcohol.

One of the most important medical problems confronting you, no doubt, is that of pregnancy. The hopeful mother-to-be may anxiously ask you, "Oh doctor, do you think I am *finally* pregnant?" or the good woman of thirty-two, already the mother of five or six youngsters born about a year apart, begging for some relief may ask, "Oh doctor, do you really think I am pregnant *again?*" In either case, the good old-fashioned rabbit test may bat about 80 per cent for us diagnostically but the recent report of Hayden[16] of the University of Chicago indicates that proper use of now old-fashioned, physiologically normal progesterone may lift that batting average to 100 per cent. Hayden's procedure is indeed very simple and most feasible: simply that of oral administration of progesterone U.S.P., 200 mg. daily for five days. In 85 per cent of the non-pregnant patients, vaginal bleeding occurred within three to seven days after the last day of therapy. He states that in patients who have always enjoyed regular menstrual cycles, the use of progesterone-induced withdrawal bleeding as a simple physiologic but non-specific test for pregnancy or secondary amenorrhea is highly accurate, in fact in the current series there was 100 per cent accuracy. Also he noted no alteration in the course of gestation either with the standard or excessively high dosage of progesterone; furthermore, no abortion could be attributed to the use of progesterone. Thus, Hayden focuses proper attention on good old-fashioned progesterone in the age-old medical problem of pregnancy.

Other new therapeutic innovations have been presented during your meetings here or elsewhere and excellent work has been published on the more recent and very significant advances in therapy, including new corticosteroids for rheumatoid arthritis, et cetera, Orinase (Upjohn) for the treatment of certain diabetics and Diuril or chlorothiazide (Merck). A new therapeutic agent has been developed by the Ciba laboratories under the name of Esidrix (hydrochlorothiazide) and was reported at the Southern Medical Society meetings in New Orleans last week (November 3, 1958) as being from ten to twenty times more effective than chlorothiazide as a diuretic and antihypertensive agent.

Space does not permit me to elaborate now on these recent developments, but I hope sincerely that we are all alert, not only to the recent advances in our various fields of medical interest, but also to the benefits of the judicious use of some of our older stand-by drugs in some of these fields of application and thus be able to exercise good therapeutic judgment which crystallizes from examination of new drugs in the mirror of the past.

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PRESIDENTS' NAMESAKES

George Washington, Abraham Lincoln, Thomas Jefferson and Herbert Hoover—to the average American these are names of illustrious White House occupants, but to the New Jersey Blue Cross and Blue Shield Plans they simply represent the names of present-day members.

A recent survey of the New Jersey Plans' membership records revealed that seventy-four Blue Cross and Blue Shield members bear the names of former presidents of the United States. More specifically, the names of all but eleven of the thirty-two presidents are sprinkled through the Plans' membership listings.

Eleven members answer to the name of George Washington, while the names of Andrew Jackson, Andrew Johnson and Woodrow Wilson each appear eight times. James Buchanan runs a close third with seven, followed by John Tyler with five. Four subscribers carry the name of James Monroe, three of John Adams and William Harrison and two of John Quincy Adams, Thomas Jefferson and James Madison.

Also on the Plans' scrolls are Grover Cleveland, Ulysses S. Grant, Rutherford B. Hayes, Abraham Lincoln, Herbert Hoover, Benjamin Harrison, William McKinley, Martin Van Buren, James Polk and Zachary Taylor.

Of the eleven presidents not represented, seven served terms since the turn of the century. Those seven are Theodore Roosevelt, Howard Taft, Warren Harding, Calvin Coolidge, Franklin Roosevelt, Harry Truman and Dwight D. Eisenhower.

Management of Acute Toxemia of Pregnancy

By John Parks, M.D., and
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UNTIL such time as the exact cause of pregnancy toxemia is known, the management of this death-dealing disease will necessarily depend upon early detection of symptoms and empiric treatment of the associated hypertension.

Vasospasm is the basic physiopathologic change which precedes tissue hypoxia in the mother. The initiator of vasospasm possibly comes from a metabolic product of the placenta or from the uterine musculature. Certainly without a placenta, pregnancy toxemia does not occur. Hypertensive toxemia of pregnancy is more prevalent in patients who have an excessive amount of chorionic tissue as occurs with an hydatid mole.[2]

If one is experienced and will take adequate time to study the eye grounds of the patient, early evidence of vasospasm can be detected. In addition to narrowing and whitening of the arteries and venous congestion, the glistening sheen of the retinal edema becomes more evident as toxemia progresses.

Vasospasm leads to a characteristic change in the blood pressure. The diastolic pressure rises first followed by an increase in the systolic blood pressure. In clinical observation two characteristic changes in the blood pressure are important.

One is the relative rise in the blood pressure. For example, a patient who ordinarily has a blood pressure of 100/70 mm. Hg. may have severe toxemia with a pressure of 120/90. This relative rise is more significant than any accepted pathologic blood pressure level such as 140/90. A rise in blood pressure above the patient's non-pregnant normal of 20 mm. Hg. diastolic or 30 mm. Hg. in the systolic pressure should serve as a serious warning signal to the observing physician.

The second observation concerns the pulse pressure. When the pulse pressure is much greater or much less than one-third of the systolic pressure, the clinician has useful evidence of potential cardiovascular incompetency. In acute pregnancy toxemia, the rise in diastolic pressure may leave the patient with a relatively small pulse pressure. Take again the example of the patient who has a blood pressure of 120/90. Her pulse pressure of 30 mm. Hg. is much less than one-third of the systolic pressure. Such a patient practically always has associated tissue edema and is a potential candidate for convulsions and cardiac failure.

The management of toxemia of pregnancy depends somewhat upon the time when the patient is first seen in the course of the disease. Untreated pregnancy toxemia has a progressively severe course with: rapid weight gain, increasing hypertension, visual disturbances, epigastric distress, irritability, edema, proteinuria, convulsions, associated abruptio placenta, fetal death, and maternal death. (Unless the patient has chronic renal disease, proteinuria is a late sign of pregnancy toxemia). Therefore, management may be discussed under three headings: prevention, palliation, and emergency treatment.

Preventive Treatment

Preventive measures consist of careful prenatal observations to detect unusual weight gain, rise in blood pressure, changes in the eye grounds and proteinuria. If the patient reports in early pregnancy and if acceptable prenatal care is given, toxemia is *almost* a preventable disease. Adequate evaluation and correction of emotional components, reduction in sodium intake during the last two months of pregnancy and control of food and fluid balance will usually prevent any significant degree of pregnancy toxemia.

Palliative Treatment

Palliative treatment may be necessary in patients who report to the physician late in pregnancy showing some degree of pregnancy toxemia, or in those patients who fail to abide by prenatal instructions which prevent sodium accumulation, tissue

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Presented at the Michigan Clinical Institute, Detroit, March 19-21, 1958.

From the Department of Obstetrics and Gynecology, The George Washington University, Washington, D. C.

edema and hypertension. The purpose of palliative treatment is to prolong pregnancy and prevent premature fetal delivery.

What can we provide for the patient who has a mild to moderately severe toxemia occurring sometime between the thirty-second and the thirty-seventh week of gestation which may prolong pregnancy with benefits to the fetus and without danger to the mother?

She will require more than the usual amount of attention. Visits should be at least daily until it is apparent that her symptoms are lessening or becoming worse. The doctor must decide whether he wishes to treat the patient in her home or in the hospital. In either event she should receive a low sodium, high protein, high vitamin diet and possibly some type of mild sedation such as phenobarbital.

The Diuretics[7]

The prompt use of procedures which eliminate fluid retention in pregnancy usually prevent the development of serious toxemia and hypertension. Once pregnancy toxemia has been initiated the most useful corrective form of medication is one which causes sodium diuresis.

Ammonium chloride has been used for many years as a diuretic agent. It is an acid-forming diuretic and by creating an acidosis results in increased water loss associated with excretion of salts in an effort to maintain a constant osmotic balance. With the newer diuretics, ammonium chloride is seldom used because the duration of action is not as long as desired.

Acetazolamide (Diamox), a carbonic anhydrase inhibitor, has been used with moderate success. This drug causes renal loss of bicarbonate which is accompanied by excretion of water, sodium and potassium. In dosages of 250 mg., once or twice daily, acetazolamide is effective for about eighteen to thirty-six hours at one time. It is not a drug which should be used for any prolonged period of time. It should be used intermittently.

Chlorothiazide (Diuril) in dosage of 1 (one) gm. daily by mouth has been found to be the most effective diuretic with the least evident dangers. Chlorothiazide seems to block sodium and potassium reabsorption in the tubules permitting rather free excretion of these ions. This is one of the most promising diuretics which has been introduced into modern therapy. It has a wide therapeutic index, eliminates sodium, potassium and fluids efficiently, and thus far shows no evidence of producing harmful side effects. It also has a hypotensive effect and potentiates other antihypertensive drugs.[8] Experience thus far would indicate that chlorathiazide may be given daily for several weeks when indicated in the reduction and prevention of fluid retention associated with pregnancy toxemia. Finnerty, Buchholz and Tuckman[4] working in the Toxemia Clinic of the D. C. General Hospital, suggest in summer that the drug be used five days out of the week to eliminate the possibility of development of a low salt syndrome.

Organomercurial (Neohydrin) produces its diuretic action by interrupting sodium reabsorption in the renal tubule. In dosage of two tablets (18.3 mg. each) per day this diuretic appears to be safe and effective. In the presence of known kidney disease other than the vasospasm of toxemia, its use should be restricted.

The Purgatives

Castor oil should never be used as a laxative. It will not initiate labor. It nauseates, irritates, eliminates, and dehydrates. Castor oil is an excellent lubricant for fine machinery, but should never be given to an expectant mother unless she asks for it.

Magnesium sulfate by mouth has some effect in removing fluids. A much easier material to take and an equally effective purgative is *citrate of magnesia.* The advantages of such catharsis are debatable.

The Hypotensive Drugs

For purposes of palliative prolongation of pregnancy the hypotensive drugs are of limited value. In most instances these drugs are used in hospitalized patients who have acute toxemia.

Magnesium sulfate is a time-tested vasodilator and central nervous system depressant. McCall and Sass[10] have demonstrated that magnesium sulfate relieves cerebral vasospasm, increases cerebral blood flow, augments oxygen utilization of the brain, and lowers blood pressure. We prefer to give this drug by the intravenous route. Up to 2 gm. of a 10 per cent solution may be given slowly. While giving magnesium sulfate the patient should be observed for unusual flushing, sweating of the upper lip, nausea, irregular pulse, and loss of knee jerk reflex. If any of these untoward symptoms develop (as the result of the injection of the magnesium ion) they may be counteracted by giving

10 ml. of 10 per cent solution calcium gluconate intravenously. Magnesium sulfate may be useful in some patients with impending or actual convulsions. It is an excellent anticonvulsant.

The Rauwolfia drug (Serpasil) is another central nervous system depressant and secondarily a vasodilator. Given by mouth it takes three to five days for this drug to become effective. Administered intramuscularly, 2.5 mg. at eight-hour intervals, it is very useful to decrease central nervous system sensitivity.[6] Thus the effectiveness of other drugs, particularly the barbiturates and veratrum viride is increased. One of the important side effects of Rauwolfia is nasal congestion which may be present in both the mother and the new born infant. Nasal congestion has an even greater influence on the breathing mechanism of the child than on that of the mother.[1] The anesthetist should know if Rauwolfia has been used and particularly if it has been used for any long period of time. It is very easy to over-anesthetize such a patient, especially if pentothal sodium is used.

Veratrum viride (Unitensen), a synthetic alkaloid derivative of veratrum viride, may be given alone or in combination with Serpasil in a dose of 0.5 mg. intramuscularly each hour until the blood pressure is at a desired level.[5,6] If this is not an effective dose, it may be increased to 0.6 or 0.7 mg. each hour. Unitensen stimulates the vagus at the medulla and causes slowing of the heart rate with an associated fall in blood pressure, frequently accompanied by nausea and some vomiting. Evidences of overdosage include sweating, pallor, shock, hypotension, nausea and vomiting. The antidotes for such symptoms are atropine sulfate 0.4 mg. (or more) intramuscularly, and oxygen. Some patients may show a tachyphylaxis to Unitensen after continued usage. This is usually corrected after a period of withdrawal of the drug.

Hydralazine Hydrochloride (Apresoline) is a drug which reduces hypertension and theoretically increases renal flow. The dosage of this drug in pregnancy toxemia is 10 mg. by mouth four times daily. For rapid action 10 to 20 mg. may be given intravenously.

Sodium nembutal is given slowly where sedatives are necessary to control convulsions, using 250 to 500 mg. intravenously.

Morphine Sulfate is rarely used in antepartum patients. Unless it is given deeply into the muscle, morphine is absorbed slowly and tends to have a dangerously cumulative effect. Our best results have been obtained by a combination of the antihypertensive drugs and diuretics.

Emergency Treatment

In emergency treatment of acute toxemia, the physician is concerned with the various methods of dealing with pulmonary congestion, cardiac failure, convulsive states, fetal distress, and prematurity.

One of the real hazards of acute convulsive toxemia is death from aspiration and strangulation. It is unsafe to give heavy sedation of any type unless the patient's stomach is empty. In impending cardiac failure with rales at the base of the lungs, the patient should be hospitalized, given oxygen and rapidly digitalized. As a temporary measure, bloodless phlebotomy may be useful.

For patients with respiratory obstruction which cannot be overcome by the usual measures of aspiration or endotracheal intubation, tracheotomy may be a lifesaving procedure.[3]

In progressive toxemia of pregnancy, urgency of delivery requires careful consideration. Delivery should be accomplished with the least amount of trauma to the mother and fetus. If pelvic examination shows the cervix to be favorable and the pregnancy is near term, labor should be induced by rupture of the membranes. If necessary, carefully controlled intravenous pitocin stimulation may be used.[9] If the cervix is unfavorable and if pregnancy toxemia is progressing rapidly, cesarean section delivery is the method of choice. The only truly corrective treatment of pregnancy toxemia is delivery of the fetus and afterbirth.

The anesthetic used should be one providing relief of pain, relaxation of patient without relaxing the uterus, and adequate oxygen. It has been our experience that this is best accomplished by sodium pentothal, ethylene and oxygen.

After delivery all danger is not over. In our experience at least 10 per cent of the patients who have shown no evidence of prepartal toxemia have a significant and threatening rise in blood pressure during the first hour after delivery. The advantages of nine months of attentive prenatal care may be counteracted by failure to carefully observe the patient in the first hour following childbirth. Approximately 25 per cent of all patients with eclampsia have their first seizure in the postpartal period. An acute rise in blood pressure after delivery should be treated immediately. The best results have been obtained by the use of veratrum and sodium nembutal in the dosage stated previously.

Another acute, but relatively rare, postpartal condition, in the patient with toxemia is puerperal vasomotor collapse. This condition as described by Tatum and Mule[11] is similar to the Addisonian crisis characteristic of acute adrenal insufficiency. Immediate administration of isotonic or hypertonic (3 per cent) sodium chloride solution intravenously will restore vascular tone and produce prompt recovery.

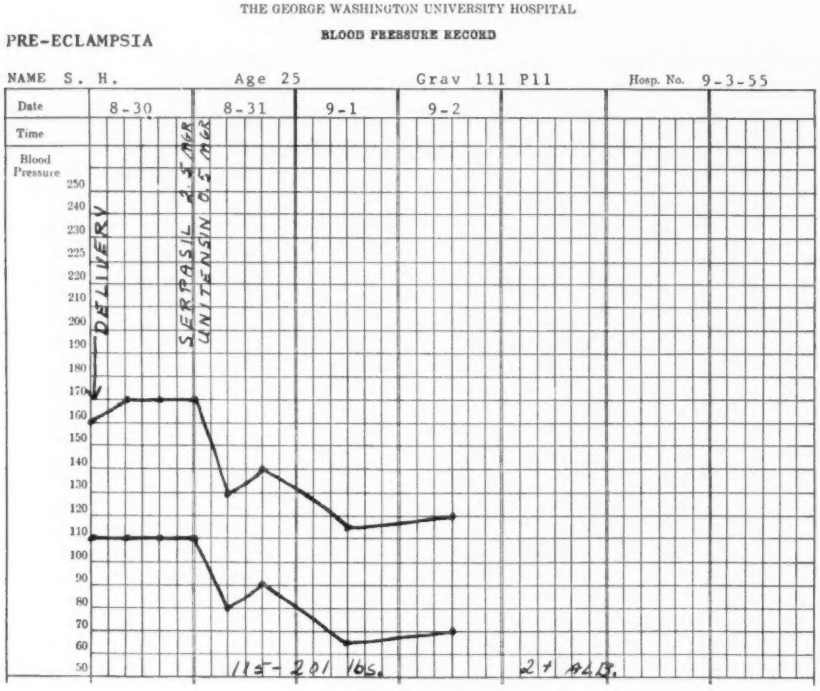

Chart 1.

Report of Cases

Case 1.—Gravida 3, para 2, aged twenty-five, gained in weight from 115 to 201 pounds. The patient had had no prenatal care. Urine showed 2 plus proteinuria. She delivered immediately upon admission to the hospital. Her postpartum blood pressure remained at 170/100 mm. Hg. until Serpasil 2.5 mg. and Unitensen 0.5 mg. were given. The immediate effect of these hypotensive drugs was that her blood pressure returned within forty-eight hours to her normal of 120/70.

Case 2.—A negress, aged twenty, primigravida, had no prenatal care. Her blood pressure on admission to the hospital was about 300/150 mm. Hg. She was having convulsions in approximately the thirty-sixth week of pregnancy. Her weight gain had been from 200 to 250 pounds. The urine showed 4 plus proteinuria. This patient's blood pressure indicated that she had severe toxemia superimposed on hypertensive cardiovascular disease—shown by the relatively constant pulse pressure regardless of variations in the blood pressure.

She was immediately placed on Serpasil and Unitensen. The convulsions were controlled. Physical examination showed the cervix to be long and uneffaced. The patient had generalized as well as marked, conjunctival edema. It was believed advisable to terminate the pregnancy by cesarean section.

Use of a cesarean section might be considered a debatable procedure, but in fulminating, progressive, severe eclamptic toxemia, delivery by cesarean section may be indicated after the convulsions have been controlled. In addition to hypertension, conjunctival edema and oliguria are indications for immediate termination of pregnancy by the safest means possible.

Conclusions

Pregnancy toxemia represents one of the truly reversible physiopathologic hypertensive diseases occuring in early life. This is a temporarily ac-

quired, almost totally preventable hypertensive disease of pregnancy which directly affects the lives of two individuals. The vasopressor factor causing pregnancy toxemia remains unknown, but excellent progress has been made in the prevention and in the emperic treatment of this potentially fatal maternal-fetal syndrome.

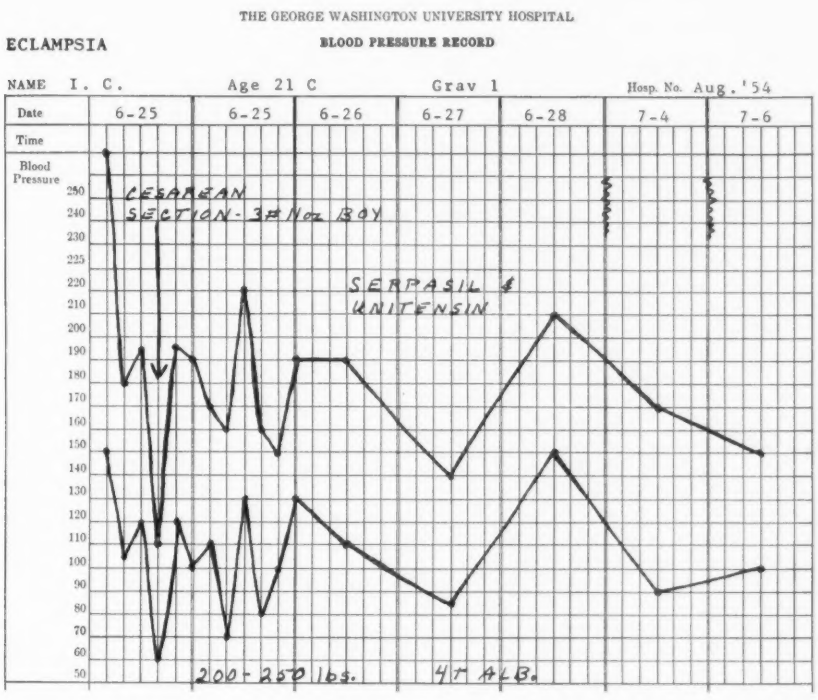

Chart 2.

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Operative and Office Accessories

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FOR several years the writer has been interested in the subject of instrument control as related to posture, vision and magnification. Also, ophthalmologists (of which group he is one) are called upon to perform lengthy, delicate procedures and are consulted regularly in regard to visual problems.

Whenever about to do time-consuming or fine work, an operator might well ask himself, "Exactly what would be the best position for me to assume in relation to the patient and would glasses or magnification be a help? Must I work standing? Would it be possible to use arm or hand rests and would these result in more comfortable, accurate work?"

Unfortunately the above questions are seldom asked because in most operating rooms and offices there is a certain amount of standard equipment available and the physician is expected to use it and is adjusted to using it. Nevertheless, if he thinks that additional equipment and aids would be of value he should obtain and use them.

At times, one almost has to work standing as when one performs an abdominal operation upon an adult. When standing he is able to obtain some instrument control by keeping his arms close to his chest (Fig. 1). Also, at times, he is able to steady his hands on the patient's tissues or upon retractors without actually using the patient's body as a support, (Fig. 2). In either case, when standing erect the operator's eyes are about 22 inches from the area of operation. Although vision at this distance may be good, it is not the distance of choice for the most accurate vision,[5] especially in the presbyopic individual, even with glasses. Head worn magnifiers cannot be used. The position is most satisfactory where delicacy of touch and conservation of energy is not of paramount importance. It is best suited for operations of short or medium length in duration on large or coarse tissues.

Sometimes the surgeon stands and bends well forward (Fig. 3). This is a difficult and exhausting position though the operator's vision is better. However, if he is presbyopic, his lenses must usually be focussed accordingly. By bending still further forward, he is able to use head worn magnifiers. This posture is suitable only for short operations on moderate sized tissues and areas. The operator may vary between the positions mentioned during the same procedure, although this is only partially satisfactory. Presbyopic surgeons will often need some type of trifocal lenses if they vary the position of their head.

A surgeon can best carry out lengthy, delicate operations in the sitting position, with arm and/or hand rests,[5] using proper glasses and head attached magnifiers (Figs. 4 and 5).[3,4,6,7,8] An adequate posture is so important that obtaining a satisfactory operating table is worth the trouble. If possible, the operator should be able to place his knees under the table; otherwise, he may use his knees as arm rests.

When operating while sitting, the presbyopic surgeon needs different glasses than when standing. Thus he should have obtained and tried multiple pairs of lenses with various focal lengths and various sizes, numbers, and shapes of segments, as well as single vision lenses of different focus. He should no more insist on one pair of lenses for all uses than he should insist on one pair of shoes for house, office, hunting and evening wear. As an aid in selecting lenses, he should make use of such aids as the Univis Professional Visual Demonstration Kit[9] and the "Guide to Occupational and Visual Needs."[2] In the latter, he will note for example that a commercial photographer uses three different pairs of multiple focal glasses for the several different aspects of his work.

While sitting, the operator can wear head magnifiers. They facilitate accuracy and can be used all or part-time. The popular song "There is nothing you can do that I can't do better," might be changed to read, "There is nothing you can see that you can't see better." Many physicians do not own a pair of magnifiers, whereas they should have one or more, or a bifocal pair. Those that slip over the head are the most convenient. The author's bifocal magnifiers[4] are approximately 2x magnification below and 4x above (commonly used strengths), and do away with the need of two

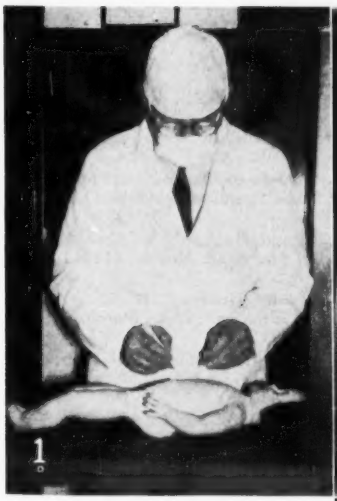

Fig. 1. Operator standing erect, upper arms supported by chest wall, hands slightly lower than elbows and unsupported. Eyes are about 22 inches from operated area, too far for the most accurate vision, especially in the presbyopic individual, even with glasses. Head magnifiers cannot be used with the operator in this position. (Most satisfactory for medium length relatively coarse procedures where delicacy of touch and conservation of energy is not paramount.)

Fig. 2. Same as Figure 1, except surgeon is steadying his hands on the patient's body. (This helps the operator, but is not always possible or best for the patient.) Suitable for medium length and medium coarse operations.

Fig. 3. Same as Figure 1, except surgeon is bending forward. This is a difficult, exhausting way to stand, although it gives the surgeon better vision. He would need to bend still further forward to use magnifiers. (Suitable for short operations only. Using Positions 1, 2, and 3 at the same operation only partially solves the problems involved.)

Fig. 4. Surgeon comfortably seated at a suitable operating table. An excellent position for working with ease and accuracy over an extended period. The surgeon's head is about 14 inches from the operative field for best vision. A head attached magnifier can be used without trouble. (Note: The average Operating Table is designed for general use and not suitable for many specific uses.)

Fig. 5. Instrument Control. Same as Figure 4, except operator supports (steadies) his arms on his knees.

pair. The focal lengths of the 2x ones is about 10 inches, of the 4x ones about 5 inches. If the 4x magnifiers are used for anything other than inspection of the field, the tips should be sterile because the hands may touch them. These strengths are usually worn over "distance glasses."

Magnifiers that fit on the nose like spectacle frames require more adjustment—often have to have the operator's prescription ground into them due to the difficulty of fitting them over other glasses and they are comparatively fragile. Magnifiers held in the hand or by an assistant or fixed upon a support are valuable. The larger they are in diameter, without aberration and distortion, the better. A monocular magnifier held close to the operator's eye is not satisfactory. A magnification

of about 10x can be obtained by using the appropriate parts from a biomicroscope,[1] but the field is so small and the illumination required so great that it is not practical for common use.

Some instances where sitting, use of arm rests, special glasses, and magnifiers can frequently be used to advantage are: repair of injuries to tendons, fascias, and blood vessels as well as repair of the skin when multiple fine sutures are necessary for cosmetic reasons; operations on and around the eye; operations on infants where the parts are small; and operations on the middle or inner ear.

Conclusions

Physicians, when possible—especially when engaged in fine or lengthy work, should sit and use elbow, wrist and/or hand rests. Physicians should wear glasses more frequently and, especially if presbyopic, they should obtain experience with several strengths, sizes and types of multifocal lenses. Magnifiers are valuable and several kinds are discussed.

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COSTS OF MEDICAL SERVICES

Consumer Price Indexes

(1947-49 = 100)

	Total Medical Care	*Prescription and Drugs*	*General M.D. Fees*	*Hospital Room Rates*	*Food*	*Housing*
1958 (March)	142.3	120.2	138.3	196.4	120.8	127.5
1957	138.0	116.7	134.5	187.3	115.4	125.6
1956	132.6	113.7	128.4	173.3	111.7	121.7
1955	128.0	111.2	124.3	164.4	110.9	120.0
1954	125.2	110.1	119.9	156.8	112.6	119.1
1953	121.3	108.9	116.1	148.2	112.8	117.7
1952	117.2	107.9	113.0	139.5	114.6	114.6
1951	111.1	106.9	108.0	126.9	112.6	112.4
1950	106.0	103.9	104.0	114.6	101.2	106.1

Costs of components in Medical Care such as drugs, doctor's fees and hospital rooms have increased substantially more, as has the Housing Index. It seems that criticism has been placed on the least important offender against the public's purse.

Over a longer period of time, from 1936 through 1956, the annual increase in the medical care index has averaged 4% compared with 8.5% for hospital care, 3.4% for doctor's fees, 5% for food and only 2% for prescriptions and drugs.—Health Information Foundation, October 31, 1958.

About seven out of every ten U. S. families now have some form of protection under voluntary health insurance. The proportion of insured families has increased almost 10 per cent in the last five years.

Seventy-five per cent of the population in the Northwest part of the United States carries insurance against hospital costs. Comparable percentages for the other sections are 68 for the West, 67 for the North Central, and 55 per cent for the South.—Health Information Foundation, May 8, 1959.

Congenital Hypothyroidism

A Preventable Cause of Mental Retardation

By William H. Beierwaltes, M.D., George H. Lowrey, M.D.,
Richard A. Aster, M.D., Govind Raman, M.B., B.S.,
and Edward A. Carr, Jr., M.D.
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ALTHOUGH cretinism is a well-recognized cause of mental retardation, it is generally believed to be a relatively rare cause. Furthermore, the intelligence of most classical cretins is not raised to a normal level by treatment with desiccated thyroid. Perhaps these old observations are responsible for the lack of recognition of cretinism as a cause of mental retardation in a recent comprehensive article on the prevention of mental retardation.[8] It is the purpose of this report to renew interest in thyroid hormone deficiency as a preventible cause of mental retardation by summarizing some of our research findings on this subject during the past three years.

Brain Growth

Although a great deal of growth of the human cerebrum occurs between the second and ninth month of intrauterine life,[9] total brain weight is only 20 to 30 per cent complete at birth. Figure 1 shows that the brain rapidly approaches maximum weight during the first seven years of extrauterine life.[16]

If a child is born without a thyroid gland or if a newborn monkey is totally thyroidectomized at birth, the resultant deficiency of thyroid hormone leads to marked retardation in skeletal growth and growth of intelligence.[6]

Hypothyroidism in Early Childhood

In a recent review of thirty-six proved cretins at Lapeer and Coldwater State Home and Training Schools, we found many cretins with intelligence quotients of zero. The arithmetic mean I.Q. was 25. Figure 2 shows that when these cretins were put on desiccated thyroid on admission to these institutions, although the majority of subjects showed some increase in mental age, the maximum mental age achieved was eight years even when subjects were followed up to fifty-one years of age. The average age at which the diagnosis of cretinism was made, however, was four years. The average age at which desiccated thyroid was started was eight years. Figure 1 shows that the average cretin in these institutions lacked thy-

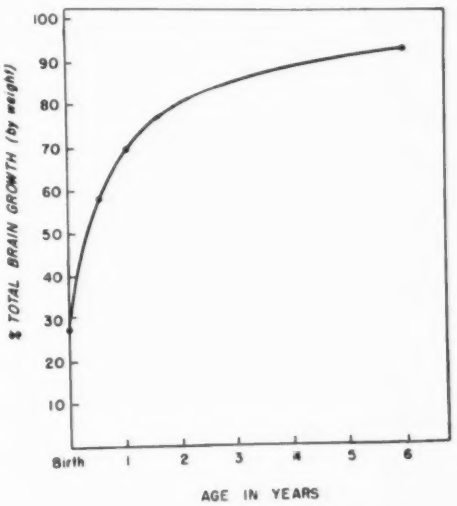

Fig. 1. Rate of postnatal increase of brain weight. (Courtesy, Fisher and Pickering, Pediat. Clin. North America, 864, (Nov.) 1957. W. B. Saunders, Co., Philadelphia.)

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Presented at the annual meeting of the Michigan Association for Retarded Children, Albion, June 27, 1958.

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roid hormone at the critical time for most of his brain growth. Apparently, if this thyroid hormone deficiency is relieved after the first few years of life, it is too late to promote the development of

For this information, we surveyed forty-nine cretins seen at the University Hospital[5] and thirty-six cretins seen at Lapeer and Coldwater State Home and Training Schools. The survey methods

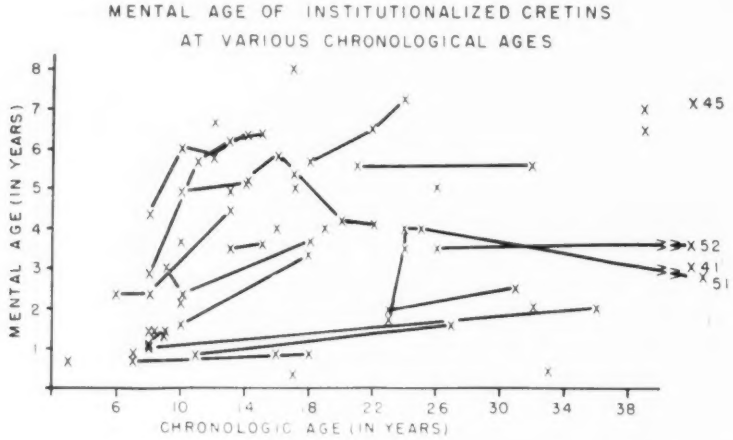

Fig. 2. Mental age of institutionalized cretins at various chronological ages on thyroid medication.

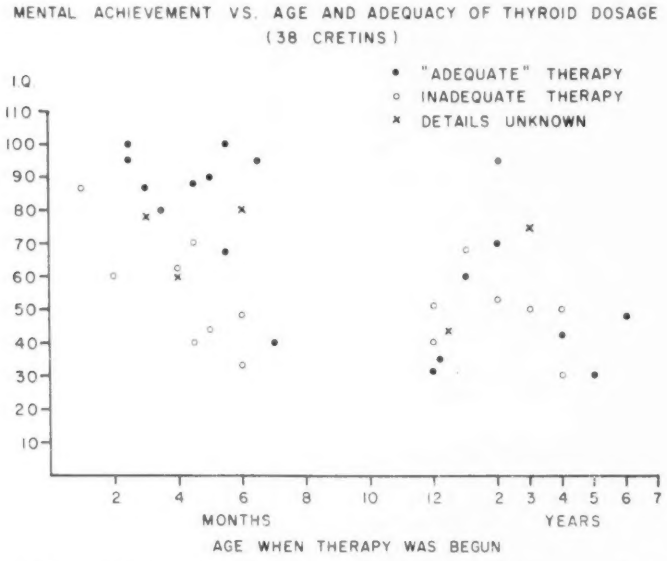

Fig. 3. Plot of I.Q. attained by cretins vs. the time at which treatment is started.

normal intelligence. The next question then is, "How can congenital hypothyroidism be recognized earlier?" If the disorder is recognized earlier and treatment is started earlier, is the end result better?

were: review of all previous hospital records of the cretins, review of parents' records of the children, complete medical history and physical examination of the affected child, and the performance of a basal metabolic rate, serum cholesterol, serum

protein-bound iodine, and 1, 2, 5, and 24-hour I^{131} uptake determinations.

Figure 3 shows that when the eventual I.Q. attained by a University Hospital cretin is plotted against the age of the child at the time diagnosis was made and treatment with desiccated thyroid was started, that the generalization can be made that the earlier treatment is instituted, the higher the eventual intelligence attained.

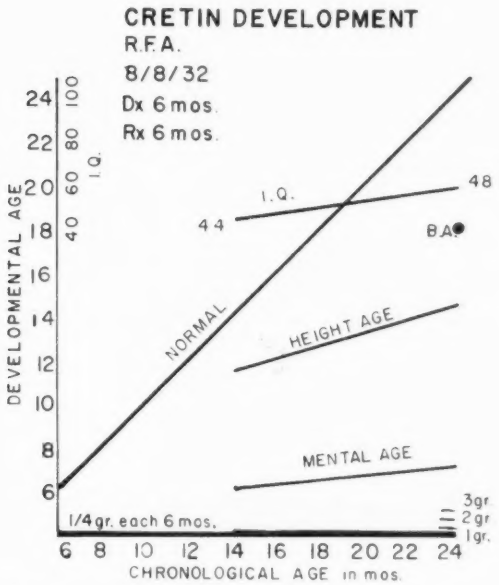

Fig. 4. An example of subnormal development when desiccated thyroid is given in inadequate dosage.

The dosage of desiccated thyroid used is also of importance. Figure 4 shows the subnormal development of mental age, height age, and I.Q. when small doses of desiccated thyroid were used in treatment of a cretin.

On the other hand, Figure 5 demonstrates the optimum type of response of these indices when larger doses of desiccated thyroid were used in the treatment of another cretin. These findings have recently been made independently by Smith.[12]

Early diagnosis is important, then, but how can the diagnosis be made early? The diagnosis of cretinism characteristically is made late because the classical features, such as protruding tongue, pot belly, and obvious retardation do not become recognizable as a rule until three to six months of age. In our review of eighty-five cretins, we found that some features are recognizable at birth, and some features occurring in the first few weeks after birth may tip off the prewarned physician that the child is hypothyroid (Table I).

We also found that the conventional tests of thyroid function, the BMR and serum cholesterol, were of little value for early diagnosis. It is impractical to perform a BMR on a newborn. The serum cholesterol, as shown in Figure 6 does not become elevated until later.

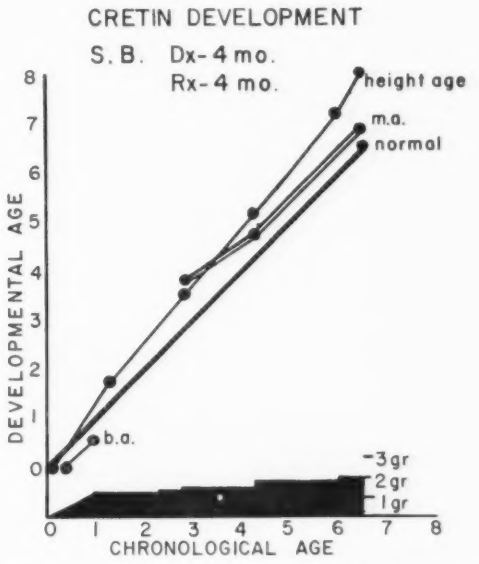

Fig. 5. An example of optimum development when desiccated thyroid is given in adequate dosage.

TABLE I. CLINICAL FINDINGS IN CRETINS

At Birth:
1. Umbilical hernia
2. Prolonged cyanosis
3. High birth weight (over 9 lbs.)

Post-Natal: (In order of appearance)
1. Feeding difficulty
2. Retarded growth
3. Prolonged icterus neonatorum
4. Respiratory distress with cyanosis
5. Constipation
6. Lethargy and somnolence
7. (Anemia)
8. Dry skin
9. Hypothermia
10. Bradycardia
11. "Classical" cretinoid features

Figure 7 shows that the alkaline phosphatase, when subnormal, is a helpful test in the detection of hypothyroidism, presumably because bone growth is subnormal when thyroid hormone is deficient.

Figure 8 shows that the serum protein-bound

iodine was quite uniformly subnormal at early ages. The 24-hour I^{131} uptake was also uniformly lowered in the cretins tested. Bone growth was usually retarded.

the most revealing laboratory tests to confirm the clinical suspicion of hypothyroidism, can make this diagnosis earlier and start treatment earlier. This diagnostic and therapeutic program should

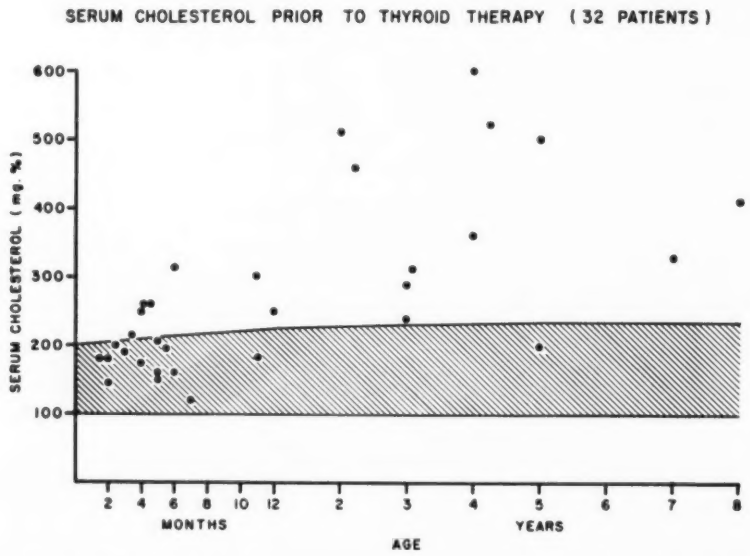

Fig. 6. Cholesterol values in cretins at various ages compared to the normal range of values. The cholesterol level rises late in the congenitally hypothyroid child.

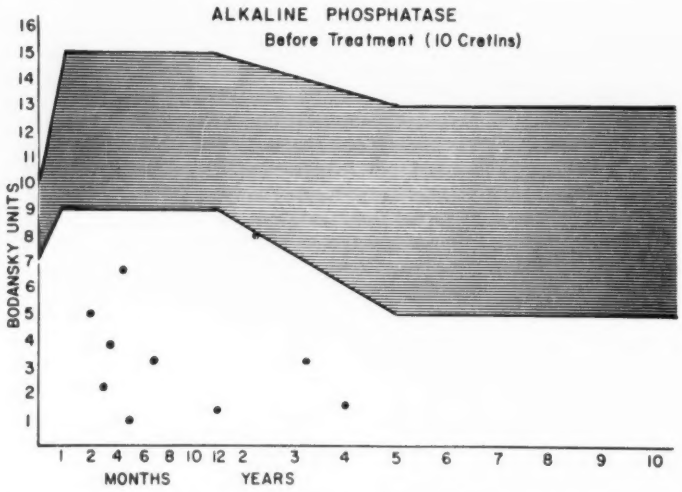

Fig. 7. The alkaline phosphatase level in cretins compared to the normal range. This test is helpful in detecting congenital hypothyroidism.

We believe, therefore, that the physician familiar with the early diagnostic features of congenital hypothyroidism, and able to intelligently select

produce the development of normal mental age in the affected child.

We found two bits of evidence, however, which

suggested that we should turn our attention to the environment of the child before his birth, for an attempt at optimum prevention of mental retardation associated with deficiency of thyroid hormone. First of all, some cretinous children who developed intelligence quotients within the normal range after prompt and adequate thyroid therapy, still had intelligence quotients significantly lower than the quotients of both parents. Secondly, whereas the normal child has a distal femoral epiphysis and a talus bone present in the leg at birth (Fig. 9a), the cretin usually has not yet developed these bones (Fig. 9b).

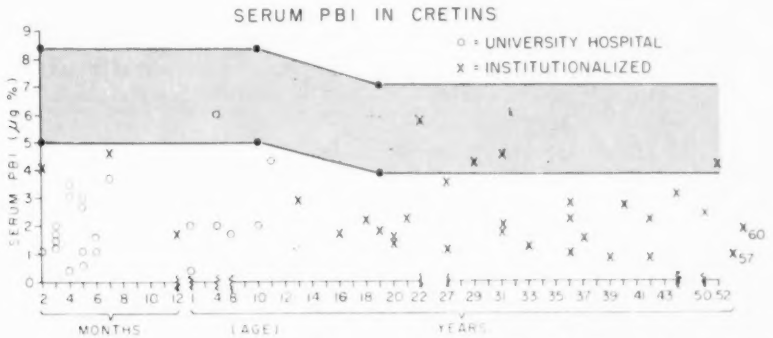

Fig. 8. The serum protein-bound iodine was quite uniformly subnormal in cretins at the ages tested.

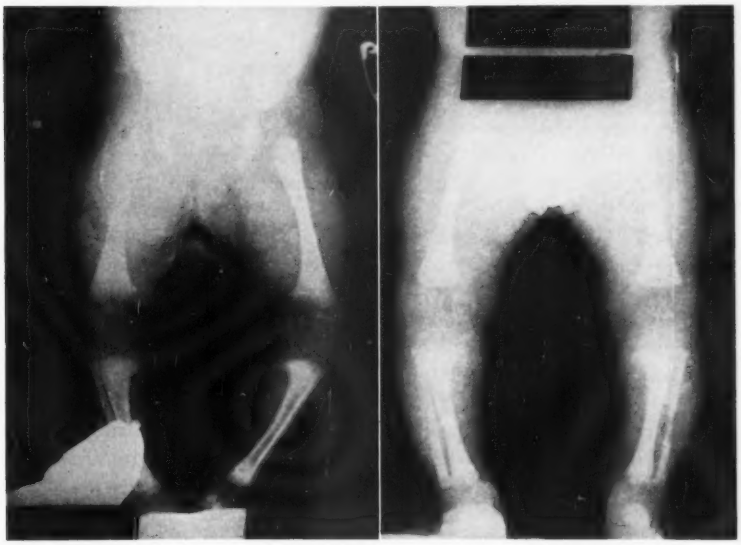

Fig. 9. (a) The distal femoral epiphysis and talus are normally present at birth. (b) These bones are usually absent from the leg of a newborn cretin.

We then posed three questions to answer about intrauterine thyroid hormone deficiency: If the mother is hypothyroid, will she drain off enough thyroid hormone from the fetal circulation to cause retardation of fetal development? If the fetus has an underactive thyroid gland, will he concentrate enough of his mother's circulating thyroid hormone through the placenta to promote his normal development? Lastly, if the birth of a cretin could be predicted, could the mother be given enough desiccated thyroid to produce a net transfer of thyroid hormone across the placenta from the mother to fetus sufficient to allow normal development of the fetus?

We have accumulated two bits of evidence bear-

ing on the first of these questions. In a comprehensive survey of the thyroid function of sixteen mothers of cretins, all but one of the mothers were euthyroid.[3] It is unlikely, therefore, that hypothyroidism in the mother is the usual cause of fetal hypothyroidism. Table II adds further evidence we have gained from work on pregnant dogs.[3]

TABLE II. EFFECT OF SURGICAL THYROIDECTOMY ON THE MOTHER DOG AND EFFECT OF FORCED FEEDING OF DESICCATED THYROID TO MOTHER ON MATERNAL AND FETAL SERUM PBI CONCENTRATION

Number of Dogs	Treatment	Maternal PBI at Delivery (ug%)	Newborn Pups			
			PBI (ug%)	Inorg. Iodide (ug%)	Thyroid / Muscle I^{131} conc.	Mean Thyroid Wt. (mg.) / Body Wt. (g.)
4	None	2.1*	3.2	—	2940† (2250-3630)	0.19
5	Thyroidectomized 9 to 50 (mean 33) days before delivery	1.3*	3.7	—	2800 (2350-3250)	0.19
1	Thyroxine fed	17.3	6.1	<10	2760	0.17
1	Thyroxine fed	25.0	—	—	433†	0.21
1	Thyroxine fed	25	7.3	>10	—	0.27
1	Thyroxine fed	30	16.8	0.4	—	0.15
						0.20

*Signif. difference ($P < .05$)
†Signif. difference ($P = .05$)

When pregnant dogs were thyroidectomized, the fetal serum concentration of PBI was normal at delivery while the maternal serum PBI dropped to a hypothyroid range of values. These data do not prove that the hypothyroid mother drains no thyroid hormone from the fetus, but they do indicate that the mother does not drain enough thyroid hormone from the fetus to normalize her deficient blood concentration of thyroid hormone. The hypothyroid mother also does not drain enough thyroid hormone from the fetal circulation to decrease the serum concentration of thyroid hormone in the fetus.

We have no information as yet on the reverse situation, i.e., the hypothyroid fetus and his use of maternal thyroid hormone. It is probable, however, that the usual cause of cretinism is fetal thyroid hypofunction with inadequate maternal thyroid hormone in the fetal circulation available for fetal use.

Table II also supplies information on the last question. It can be seen that when the mother dog is fed excessive doses of desiccated thyroid, her serum PBI rises and the fetal serum PBI also rises.

We have recently applied this last bit of information to human beings.[3] A woman who had already given birth to two cretins, and therefore, according to information gained in our survey of eighty-five cretin families, was likely to give birth to a third cretin, was started on desiccated thyroid before she became pregnant for the third time. As the dosage of desiccated thyroid was raised during pregnancy to 22 grains per day, her serum PBI level rose to high levels. The serum butanol extractable iodine, BEI (or "thyroxine-like iodine")[7] rose also.

At birth, the fetal BEI was normal. Roentgenograms of the leg showed normal bone maturation. A fall of the serum BEI to subnormal in five days after birth, however, and a subnormal I^{131} thyroid uptake test after TSH stimulation proved that the child had true primary hypothyroidism. This evidence indicates that the birth of a cretin was predicted and normal intrauterine growth apparently was produced in spite of the fact that the fetal thyroid function was subnormal.*

Lastly, we have produced some evidence that congenital hypothyroidism may be a more common cause of mental retardation than was formerly suspected. We know that some sporadic[11] and most endemic cretins[4] have thyroid glands. When we performed I^{131} uptake tests on thirty-six cretins at Lapeer and Coldwater, we demonstrated that one-third of these cretins had thyroid glands. Ap-

*This child returned at one year of age and had normal intelligence.

parently, insufficient thyroid tissue in the neck of cretins can respond to endogenous TSH stimulation by regenerative functional hypertrophy and hyperplasia since older cretins have been described with normal serum protein-bound iodine values,[14] goiters,[13] and even the classical picture of thyrotoxicosis.[1] It is logical to hypothecate, therefore, that a cretin with thyroid tissue could acquire irreparable mental retardation from lack of sufficient thyroid hormone *in utero* and during the first year or so of postnatal life, and then grow enough functional tissue to produce quantities of active thyroid hormone sufficient to prevent or erase the overt stigmata of cretinism except for irreversible brain damage, manifested as mental retardation and deafness or deafmutism. If this phenomenon happened in many individuals in a severe endemic goiter area, an observer might find in such an area an increased incidence of "feeblemindedness apart from cretinism . . .",[15] but actually caused by temporary hypothyroidism during the critical period of brain growth. To investigate this possibility, we studied sixty-four members of nineteen families[10] in a native village in the Northeastern Frontier Agency of India because the population of this village was characterized by a high incidence of goiter, deafness or deafmutism, mental deficiency, and cretinism. Goitrous subjects had lower serum concentrations of thyroid hormone than non-goitrous subjects. Deaf subjects had lower concentrations than non-deaf subjects. Totally retarded, non-cretinous subjects had lower concentrations of thyroid hormone than non-retarded subjects. In other words, although subjects in this goiter area with overt evidence of mental retardation did not appear to be hypothyroid, the lowered serum concentration of thyroid hormone demonstrated that they were indeed hypothyroid.

The evidence of goiters in the N.E.F.A. area of India today is similar to the incidence of goiter in the upper half of the lower peninsula of the State of Michigan in 1925 before the use of iodized salt was instituted.[2] The incidence of goiter in the northern peninsula of Michigan greatly exceeded the incidence of goiter in the area of the India study. Unfortunately, we have no record of the incidence of deafness, deafmutism, mental deficiency, or cretinism in the State of Michigan at that time, or today after thirty-five years of the use of iodized salt. If the incidence of these defects increases in proportion to the incidence of endemic goiter, as the Study Group on Endemic Goiter of the World Health Organization concluded, then it is reasonable to suspect that the incidence of these defects was at least as high in the upper part of the State of Michigan in 1925 as in the N.E.F.A. study today. This information would suggest that temporary hypothyroidism early in childhood might be a more common cause of mental deficiency and deafness than is recognized at present. If iodine deficiency were the only cause of this temporary hypothyroidism in an endemic goiter area, it would be expected that the availability of iodized salt to mothers in the State of Michigan would eliminate this cause of temporary hypothyroidism today. We know of no study in the State of Michigan where serum PBI and BEI determinations systematically have been made routinely at birth, or in apparently euthyroid young children with goiters, deafness, deafmutism, or mental deficiency to prove or disprove that the correction of iodine deficiency in the diet of inhabitants of Michigan has eliminated temporary hypothyroidism as a cause of goiter, deafness, deafmutism, and mental deficiency.

Summary

We have summarized some pertinent findings of our research on cretinism during the past three years that bear on the problem of mental retardation. Cretins institutionalized at Coldwater and Lapeer State Home and Training Schools had a mean I.Q. of 25. The average age at which their diagnosis of cretinism was made, however, was four years. They were started on thyroid at an average age of eight years. The most critical periods of brain growth are during intrauterine development and in the first few years after birth. The earlier cretins were diagnosed and treated at University Hospital, the higher the I.Q. attained. Careful review of eighty-five cretins in the State of Michigan enabled us to recognize certain clinical findings and laboratory tests that will enable the physician to recognize the presence of congenital hypothyroidism much earlier than usual. Even optimum postnatal treatment did not produce I.Q.'s as high as the parents, however. Also, most cretins at birth show retardation of skeletal growth.

For these reasons, the possibility of maternal hypothyroidism causing fetal hypothyroidism was investigated in the human and in the dog. It was concluded that maternal hypothyroidism is not a significant cause of fetal hypothyroidism. Evidence was produced in the dog and human beings that when large doses of thyroid are given to the moth-

er, substantial quantities of thyroid hormone may be transmitted across the placenta to the fetus.

Lastly, studies of serum thyroid hormone concentration in a severe endemic goiter area in India suggest that temporary congenital hypothyroidism might be a much more common cause of mental retardation than previously suspected.

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University Hospital
Ann Arbor, Michigan

"DOCTOR'S DAY" AND "HOSPITAL DAY"

Gilbert B. Saltonstall, M.D., president of the State Medical Society, was honorary chairman of "Doctor's Day" and "Hospital Day" held at the University of Michigan Medical Center. Dr. Saltonstall presided over the University of Michigan's first professional "Doctor's Day" on Saturday, May 16.

The day-long program started at 9 a.m., and included reviews, current research activities, special clinics in each department, closed-circuit television broadcasts of surgical procedures and tours of the Medical Center. Vice President Marvin L. Niehuss addressed the group at the Saturday luncheon.

On Sunday, May 17, the Outpatient Building on the east end of the Medical Center was the focal point of "Hospital Day," with a public open house scheduled from 2 to 4:30 p.m. Frederick C. Matthaei of Ann Arbor, who won election to the Board of Regents last month, was honorary chairman of "Hospital Day." Mr. Matthaei donated the University of Michigan Hospital chapel a few years ago and has long been interested in hospital affairs.

Planned to observe the ninetieth anniversary of University Hospital, the open house gave visitors a view of much of the equipment used in modern medical care. About eighty special exhibits and demonstrations occupied six floors of the Outpatient Building.

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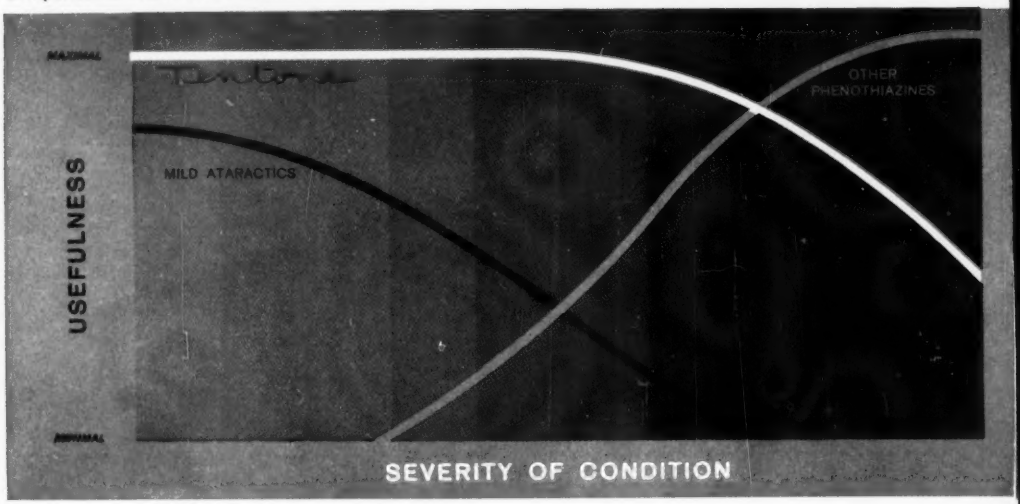

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Psychologic Factors in Gynecology

By H. T. Schmale, M.D.
Ann Arbor, Michigan

TO tackle such a problem as the psychologic aspects of gynecology in the short time available to us is, of course, impossible. Therefore I shall try to limit my discussion to several aspects which will be more in the nature of highlights than any detailed discussion. The things I would like to comment on briefly are: first, the problem of psychosomatic diagnosis, the use of this term and the present status of "psychosomatic medicine" in our hospitals; second, to deal very briefly with the problem of a true psychologic disease—namely, frigidity—and some of the factors involved in this very prevalent disorder; finally, to make a few comments on problems of relationships between doctor and patient as they are seen in the gynecologic clinic and in gynecologic practice.

Since it is impossible or, rather, since it requires great temerity, to embark upon a discussion of female psychology, I shall first beg the question by moving to something far afield. I would like to draw your attention to a study reported by Stuart Wolff in a non-medical journal, *The Saturday Review of Literature*, January 5, 1957. He stated that recent statistics show the present status of some of the diseases which have occurred in veterans who were imprisoned in both theaters, the European and the Pacific, in the last war. This study states that approximately 94,000 United States prisoners of war were taken in Europe. These men were imprisoned about ten months. Less than 1 per cent died before liberation. In contrast, in the Pacific Theater about 25,000 Americans became prisoners of war. They remained in prison four times as long as those captured in Europe and suffered far more than any others from the effects of threats, abuse, and humiliation. Their demoralization was often extreme. Over one-third died before liberation.

Six years after liberation, those who survived the Japanese prison experience were re-examined. In the first place, the total number of deaths in this group during these six years was more than twice the expected incidence for a similar group of persons not so exposed, and three times as great as the group of United States prisoners of war in Europe. The causes of death included many diseases not directly related to confinement or starvation. Nine times the expected number died of pulmonary tuberculosis; twice the expected number died of heart disease; more than twice the expected number of cancer; and more than four times the expected number of diseases of the gastrointestinal tract; twice the number from suicide; and, most strikingly of all, three times the expected number of deaths as a result of accident.

I think that this information enables us to see the validity of a broader approach in medicine which would include a larger framework in which to view illness. In such a framework, the problems of adaptation, human ecology, and the effect on disease of privation and the forcing of the organism back to more primitive responses can be seen. It is not my purpose to discuss this problem further except to draw it to your attention as a very basic factor in the understanding of psychosomatic medicine.

It is my thesis that psychosomatic medicine, as viewed in the framework of ecology, is concerned with responses which are far beyond the usual psychologic responses of anxiety and may better be discussed in using such a term as *organismic distress*. It is here that I feel that the problem of psychoses, the problem of chronic disease, of hypertension, et cetera, may be related. However, in general practice, our use of this term has become a hybridization and bastardized term which embraces all sorts of emotional disorders and is used because it has a more "scientific sound." It seems to me that we should rigorously restrict this term and use it in regard to diseases of "unknown etiology" which have both an organic and emotional factor (or which we suspect have) and reserve the term, bad as it still sounds, *neurosis*, for those disorders which are more purely psychologic in the sense that their psychologic roots can be more easily determined. It is, of course, a truism that these fields overlap tremendously.

I think it would now be possible for us to narrow

Presented at the Michigan Clinical Institute, Detroit, March 21, 1958.

our frame of reference to a discussion of frigidity. This disorder has been estimated by Weiss and English to occur at least in 50 per cent of the married women. Other estimates make it much higher. Physical and constitutional factors may of course be presented in frigidity but these, it seems to me, are the least important.

Frigidity is an example of a psychologic entity which, due to basic unconscious infantile fears, inhibits the functioning of the sexual apparatus. Surprisingly little time and attention is given in our instruction of medical students to this vital aspect of human functioning which perhaps can best be understood by the man when stating that it is analagous to impotence. Basic difficulties in the woman usually relate to strong aggressive impulses which have had to be inhibited by the very fact that the little girl is not allowed to express these. Masculine strivings are usually also present. Revenge fantasies and specific traumatic events may also contribute to the causation of this condition. However, the point I would like to bring up for your consideration is the essential difference between this inhibition in the male, where it becomes a very distressing symptom, and in the female, where it can be hidden.

Because the woman can, by hiding her frigidity, continue to function, to bear children, much of the symptomatology developed about the basic frigidity is because of secondary elaborations and the bulwarks of defense and conflict that result. An increasingly difficult factor, at present, is that our culture demands the type of sexual performance which has been described in sex manuals and popular literature, performance which is often not compatible with the actual relationship that the woman experiences. This creates further feelings of inadequacies and difficulties.

The treatment of frigidity is primarily a job for psychiatrists. I know of no easy short cuts which can be applied in the gynecologic clinic and I would warn against such devices as the use of testosterone medications and emphasis on technical alterations in the marital act. I feel that these people can best be helped by psychiatrists since this is one of the disorders that does respond fairly well to psychiatric treatment. First, this is complicated by the difficulty of referral, an area in which I think the gynecologists can be most helpful by explaining the fact that this is a psychologic rather than a physiologic problem; and second, it is complicated by the fact that in the interreaction between marital partners, much of the symptomatology may be related to a finding that both partners have marked neurotic conflict, and the marriage is a result of a compromise solution of the two neuroses.

Now we hurry to the third point—the problem of relationships between the doctor and the patient in a gynecologic clinic. All of the factors that apply, in general, to doctor-patient relationships could be enumerated here and I am certainly not one to feel that consideration and care for patients is a prerogative of psychiatrists. There are many good internists, neurologists, and surgeons who are far more concerned and considerate of their patients than are some psychiatrists. However, in addition to the usual problems of doctor-patient relationships, there is the problem in many cases of the sexual difference between the doctor and the patient. It is this point that makes some women feel very misunderstood in gynecologic practice. For instance, when she is in the ninth month of pregnancy and the doctor presumes to say, "I know exactly how you feel," she is quite sure that he does not. Nor is it quite possible for a member of one sex to empathize completely with a member of the opposite sex. However, within this framework, and with a constant respect for the individual's right to know what she feels, several points may be made. In cases of difficulty in gynecologic work, the chances of the doctor being blamed are much greater than they are, it seems to me, in the general practice of medicine. Because of the intimate nature of the experiences through which women pass who have to go to gynecological clinics there is a very strong relationship developed with the doctor. In one case he will be the magical figure who brings the baby to her and to whom she attributes tremendous power when things go well. If things go badly, the gynecologist is a figure upon whom she projects all of her difficulties and all her hostility and he is always responsible in her mind for such problems as miscarriage or natal mortality.

With the things I have mentioned taken as a given added factor in the practice of gynecology, I would like to speak about some of the factors involved when crises develop. Of course, basically this resolves into problems within the doctor and problems within the patient.

I think that anyone who has worked in a teaching hospital is soon impressed by the development of what might be called the "embryo doctor's bedside manner." This develops partly from his didac-

tic instruction but more from his identification with a multitude of people with whom he has come in contact and especially his more recent identifications with those of his instructors with whom he works on the wards. In times of crisis the doctor usually falls back on what might be called his habitual bedside manner. Four general classifications might be described briefly according to an outline by Grete Bibring: one would be the good, warm, understanding doctor who has an image of himself as a helper and indeed does very well until he meets patients who are hostile and querulous. Another standard type perhaps has the "stoney, reserved, all-powerful attitude" about him. A third type might be described as the jovial, slightly-teasing type; this kind of individual often finds himself in the greatest difficulties in the gynecologic clinic where this attitude can make his woman patient feel very uncomfortable or can allow her to misinterpret it as being very erotically tinged. Finally, as a fourth category, the charming captivating attitude is often used. Now, to counteract these major types (which I wish I had time to illustrate more clearly for you) we might divide patients into three general groups: the dependent-demanding type, the hostile-querulous type, and the over-concerned and worrying patient.

The difficulties arise when the habitual mode of reaction of the doctor does not fit with the habitual mode of reaction of the patient. Therefore, a hostile-querulous individual is not going to get along very well with the doctor who uses a stoney, reserved, all-powerful attitude. Dependent-demanding patients do not get along well with the doctor who uses "good and warm understanding" because their needs seem to be insatiable. Over-concerned and worried patients do not respond well to any jovial or teasing attitudes. Therefore, it seems to me, the essential problem is to have in mind, as we all do, somewhat of a diagnostic gauge for determining the classification of our patient and relate this with some introspection to our own attitudes. By our introspection and our ability to discuss such things with our colleagues, many of the difficulties which arise can be anticipated before they start and the doctor's capacity to treat his patient is much enhanced by his increased flexibility.

This does not necessarily mean an extensive self-analysis, nor does it indicate a need for psychiatric intervention. These attitudes, I believe, are not necessarily very deep ones and can be within the purview of our ordinary everyday emotional interreaction and, as such, are changeable to a degree. Such willingness for self-evaluation and the ability to modify our own behavior should forward our growth as sound physicians.

HEALTH CARE BENEFITS FOR FEDERAL EMPLOYES

At their annual conference last week Blue Shield Medical Care Plans renewed their support of legislation which would lend assistance to the financing of health care benefits for Federal employes. The national Government is the largest employer which does not now provide some form of health benefits for its employes. This form of fringe benefit has become a condition of employment for a large segment of the population, and in this respect the Government has fallen behind the times in making provision for the better health care of its employes. Blue Shield Plans (and Blue Cross Plans) are presently serving hundreds of thousands of Federal employes by providing them with a prepayment mechanism which, lacking a Government contribution, is being paid for out of the employe's own funds. We believe that these hundreds of thousands of Government employes who are now participating in Blue Shield programs give clear testimony to the need for all Government employes to enjoy similar protection against the cost of ordinary or catastrophic illness expense.—Donald Stubbs, M.D., Washington, D. C., in Statement of Blue Shield Medical Care Plans before the Committee on Post Office and Civil Service, United States Senate, April 21, 1959.

Editorial

WHAT WILL BE MEDICINE'S FUTURE?

The Annual Conference of the Blue Cross and Blue Shield Plans, National and International, occurred at Miami Beach, Florida, April 12-16, 1959. This was the largest conference with the most delegates ever assembled. The doctors, directors of both groups, and their co-workers were dedicated people willing to listen to committee and other reports, to meet in conferences and to plan for the future—whatever it may bring. Both Plans, Blue Cross and Blue Shield, are loosely grouped into a national organization, each group representing local plans—statewide or less. Each in its own way has worked out a solution to the problem of prepaying and budgeting for medical and health services. All know they are inadequate in a very significant field. Each group, Blue Cross and Blue Shield, is still an assembly of delegates from various component parts which are self-sufficient and each the solution of a local situation, but not unified throughout the nation.

Blue Cross antedated Blue Shield by a very few years. During the years of the depression, it became evident to doctors and to hospital administrators that the vast majority of people could not finance a serious illness without calamity striking. Nature has a way of solving "unsolvable" problems. The need, the worry and the desperate conditions stimulated a few pioneer souls in many spots throughout the nation to evolve a completely new concept of the doctor's and the hospital's responsibility to their patients. The Blue Shield voluntary prepayment idea was evolved and created by a few deep thinking individuals in hundreds of areas throughout the land. They planned policies and schemes by which the people (patients) could pay for their medical and hospital needs by all joining together—all contributing—and the one in need benefiting. These pioneers added economic and financial advice to the other things being done to care for sick people. The public was taught to budget for medical and health services before they were needed rather than desperately trying to pay after a calamity had fallen. These plans were all different but all directed to a common service.

Medical and Health Services

The first ten or twelve years' experience demonstrated the complete feasibility and acceptance of a program which had been so desperately needed. No one should forget a conference with the late Senator Vanderberg, a half-day devoted to answering questions—and he knew how to ask them, too. At the conclusion of the session, he commented that without knowing it we had established a "public service trust"; we had taken $50 million of the people's money and spent it for them. We had demonstrated that if allowed, medicine can solve its problems and can give the people the health care they are demanding, while other groups are trying to force compulsory medical service upon the nation. He said that as long as we could make these programs work we would not have socialized medicine, but should we fail, socialized medicine could come within a year or two and would.

A feeling has been growing among pioneer medical thinkers—medical statesmen—that Blue Cross and especially Blue Shield are ready for new dresses. People are again demanding extra services which are not available. Labor leaders, politicians, bureaucrats are all making plans for a much more complete medical and hospital coverage than is now being offered. Suggestions have been made by our own directors during the last several years to continue to offer the services now covered in the various Blue Shield programs, but to provide riders which could include under different groupings, complete medical and health services—home, office and hospital. Blue Cross and Blue Shield could supply all the health services which are being demanded through the prepayment principle.

Labor leaders, politicians, governmental agencies, study committees and commissions have claimed that service limits were too narrow, and that home and office care—in fact, all care should be available to those who wish to pay for it. Doctors throughout the country are working the same as they have been in Michigan attempting to find the answers to these demands.

Big labor threatens to set up closed panel or-

(Turn to Page 944)

President's Message

The Norm is Shocking!

For twenty years, Michigan Medical Service has been a very real part of medicine in Michigan. During that time, hundreds of millions of dollars have been paid by the people of Michigan to MMS and it has in turn paid the doctors for the care they have rendered to their millions of patients.

It sounds easy. But the process described above has required millions of man hours, millions of pieces of paper, and millions of opportunities for trouble.

These latter millions are compounded when changes are made . . . and we have seen constant change since the inauguration of Blue Shield.

Frankly, we have been lucky in Michigan, for it comes as something of a shock to all of us when there appears a major divergence of opinion among our members on matters relating to Michigan Medical Service. It just hasn't happened here for many, many years even though it is a normal situation in some other states. These differences of opinion are bound to arise when many different people are affected in many different ways by every policy adopted and every policy change.

But the important thing is this: Everybody is really after the same thing—Good Medical Care at Reasonable Cost. And as long as the control of the situation lies in the hands of members of MSMS, we can be reasonably confident that that goal is not going to be lost sight of, as we engage in a little tugging and hauling to determine the ways and means of arriving there.

It is mighty important that we can have such confidence, for if *we* lose sight of the goal—*everybody* loses.

Delbert D. Dallenbach

President, Michigan State Medical Society

ganizations; government threatens through pending legislation to set up compulsory insurance programs; others threaten to extend our social security medical and surgical benefits and senior citizen care through increased deductions from wages and salaries by increasing the social security tax. This additional bite out of the field of independent medical practice would convert another 15 million or so persons into compulsory government health insurance, not administered by the doctors as our Blue Cross-Blue Shield programs are, but by bureaucrats and politicians who will dictate terms, hours and services.

The American Medical Association, at its meeting in December, pledged care for "persons over sixty-five with restricted and inadequate incomes." At its original inception, Blue Shield accepted these people in groups and never cancelled their contracts on account of age. The plans are now willing to accept subscriptions also in the older age group. Adequate programs have been suggested whereby the medical attention can be given with slightly reduced payments—but suitable ones. The success of this plan depends completely and entirely upon the willingness of the doctors to accept the responsibilities and (in this limited group) being willing to work for what is available.

COME, MIRACLE!

Blue Shield must have a new birth. More benefits and more areas of service are being demanded, schedules of payment and premium rates have been studied and are being restudied. For the past two or three years, a complete new program has been evolved in Michigan. Every doctor and every specialist society was asked to co-operate in setting up schedules and fees which they would be willing to accept for those persons actually under the income limit. Fee schedule committees are still working. The House of Delegates instructed that a Michigan Relative Value Scale be established but that pending that action, a modified California Relative Value Scale be used. Some of our specialty societies and doctors failed to help in setting up these schedules but promptly complained of the temporary schedules which were established. The fee schedule committees are still working on an adequate relative value scale and still hope the doctors will co-operate and help develop a workable program which could be accepted by all.

The consensus of the many hundreds of delegates to the Blue Cross-Blue Shield Conference at Miami Beach was that dictated compulsory medical services taken out of the governing hands of the medical profession is a possibility in the very near future. Blue Cross and Blue Shield representing the hospital group and the medical profession, can solve the problem, but only with the co-operation of the doctors who will be rendering the service, and the hospitals which also have a very critical responsibility. Working together, each helping, can work miracles—and we need a miracle!

TO CORRECT MISINFORMATION AND MISAPPREHENSION

A critical discussion before a group of younger doctors at the MCI Session in Detroit, March 10-14, 1959, spotted a frequent and serious criticism of Michigan's M-75 new Blue Shield program. It was alleged that a wife or employed person who earns a smaller income can, and is, allowed to apply for the family benefit coverage. A protest that such subscription and benefits would be governed by the major income of the family was immediately denied and a case cited: the office nurse of a doctor, earning $4,000 a year, is said to have called "headquarters" and to have been told she could subscribe under plan B (less than $5,000) for herself and family. She said her husband earned $8,000 and was told "that made no difference." Inquiry among many well-informed doctors (several being members of the Board of Directors of Michigan Medical Service) showed the same misapprehension: "unfortunately that loop-hole exists." It was even stated that there is no printed statement anywhere that the major income is the controlling one in the contract.

The Facts

In group contracts and employee withholding, the employer automatically places the subscriber in the proper class A, B, C or D, according to income. In the "Income Not Certified Application Card," the last section contains a block for indication of A, B, C or D, with a listing of income levels and the statement to be signed, *"I certify that the annual income of the principal contributor of my family as checked below is true and correct."* (signature, date). It is evident the charges and criticisms reported here were anticipated and

proper precautions written into the application blank.

Participating doctors have promised to render services to their patients as indicated. In cases of multiple income producers, the doctor usually knows the situation and should make his own understanding with his patient. Any later criticism or accusation of making unjustifiable "extra charges" would then be avoided. Labor groups and others are now making such accusations and giving the medical profession unfavorable publicity. See "Sky-High Medical Bills" in *Parade*, April 12, 1959.

BLUE SHIELD FUTURE

Comments by Carlton E. Wertz, M.D., President, Blue Shield Medical Care Plans, Buffalo, New York, are of significance:

". . . I have appreciated more fully than ever before the immense importance of Blue Shield to the preservation of our private medical care system and its unsurpassed record and achievements in the service of the nation. . . . I wish to appeal to you to remember that Blue Shield has an identity entirely its own. It represents medicine's own answer to the problem of financing medical care. The profession founded Blue Shield and has fostered its development as a fiscal arm of medicine to serve the patient's need for a means of paying the cost of his medical care. As such, Blue Shield occupies a unique and responsible place in our present-day medical care system. We must, therefore, keep in mind that Blue Shield must look to medicine for leadership and aggressively seek medicine's guidance in developing extensions and refinements of its program . . . we must face this fact—Blue Shield can neither trust to luck nor rely on past attainments in shaping its future. In plainer language, Blue Shield Plans must mount a powerful offensive in seeking new and imaginative solutions for the problems facing the nation in its search for continuingly improved methods of financing the cost of medical care. . . .

"It is well known that special interest groups are engaged in a variety of efforts to change our present system of medical care. The closed panel plans are but one example of the direction these efforts are taking. . . . In addition, there are political forces at work which seek to put medical care under the control of government. The Forand Bill is a manifestation of this and should serve as a warning that the voluntary programs such as Blue Shield must realize that the amount of time available to us to meet these and other threats to our present system of medical care is constantly diminishing. We must, therefore, make every hour and every day count heavily in the attainment of the goals we set out to accomplish. . . .

". . . We must realize that the medical profession has a measure of responsibility to shoulder in behalf of Blue Shield. Furthermore it seems perfectly clear that the profession must recognize Blue Shield for what it is and identify its role properly in relation to the function it performs in behalf of medicine. I believe, for example, that we should abandon as fruitless the argument over whether Blue Shield was created exclusively to combat federal health insurance. I think it is time we cease debating whether Blue Shield was created to provide coverage exclusively for the medical indigent or the patient of limited means. Such argument creates a smoke screen and obscures the fact that the Blue Shield program was developed to meet a larger and more universal economic need. Indeed, Blue Shield is a program designed to serve the people's need for a means of budgeting the cost of medical care—a 'commodity' that has grown more costly as its frontiers have been broadened through research and the development of newer and more effective techniques of treatment. Seen in this light, Blue Shield is seen to have a place in our present credit economy as well as in the structure of private medical practice. On the one hand it conforms to accepted patterns of family budgeting and on the other, it has materially strengthened our system of private medical care by providing it with sound economic moorings without disturbing any of the traditional concepts of the private practice of medicine.

"I am convinced beyond a shadow of a doubt that a progressive Blue Shield program sensitive to public need and to professional control and guidance is the one best way to secure for future generations the unparalleled advantages of our American medical system. I am equally convinced that to serve the nation fully the profession must take a direct and active part in all future developments in Blue Shield. Medicine must extend the benefits of Blue Shield to an ever greater segment of the people. It must keep its sights high in developing newer and better forms of coverage. It must gear its program to the needs of an aging population. It must meet competition squarely and effectively in the national as well as the local market place. It must communicate effectively with the profession to keep medicine informed of new goals to be attained in extending and preserving the principle of voluntary prepayment in the face of whatever pressures that may develop to change our present system of private medical care.

"And let me remind you all of this. There was a time within the memory of us all when working in Blue Shield was looked upon as high adventure instead of a job. There was a time when the development of new ideas in Blue Shield was seen as a challenge instead of a chore. There was a time when being a part of Blue Shield was looked upon as being in the mainstream of a social and economic movement essential to the welfare of the people. And no one thought of it as a prosaic business enterprise. We need the spirit of those times today. We need to recapture those attitudes. They are indispensable if we hope to foster greater progress in Blue

Shield and secure for the people of this nation the enduring values of private medical care financed through voluntary effort. Let us resolve to call upon the best and highest order of performance we are capable of and apply our energies to the development of a new era in Blue Shield. Let us provide a workable program of coverage for the aged. Let us prepare to market a national program of coverage for employers seeking such coverage. Let us undertake to co-ordinate our individual enrollment efforts so that Blue Shield coverage can be offered as a simultaneous nation-wide effort. Let us seek new forms of coverage and refinements in our existing programs so that Blue Shield will be the pace-setter in its field. And above all let us develop a progressive, alert and forceful national organization and leadership in keeping with our growing responsibilities to the national community. I urge you to consider carefully the responsibilities we must discharge. The faithful performance of the tasks ahead of us will determine whether Blue Shield and, indeed, all voluntary forms of prepayment will survive. Let us be about our work with determination."

MEDICAL CARE FOR FEDERAL CIVIL EMPLOYEES

Blue Shield Plans throughout the country support legislation which would lend assistance to the financing of health care benefits for employees of the Federal Government, Donald Stubbs, M.D., Chairman of the Board of Directors of the National Association of Blue Shield Plans, told a Senate Committee on April 21.

Dr. Stubbs testified on behalf of the nationwide Blue Shield Plans before the Committee on Post Office and Civil Service, which is conducting hearings on Senate Bill 94, a bill providing for Government contribution toward health service benefits, including basic coverage and major medical insurance for civilian officers and employees in the U. S. Service and their dependents.

In his statement, Dr. Stubbs indicated that Blue Shield would generally favor legislation to provide:

1. That all qualified carriers have an opportunity to offer coverage.

2. That employees should have a free choice, subject only to the enrollment requirement of the carrier to select the plan of coverage which seems best to fit his needs.

3. That a Government contribution toward the cost of coverage be sufficient to enable employees to get better coverage than they may now have.

4. That payroll deduction be made available to assist the employee in paying his share of the cost.

Dr. Stubbs emphasized that Blue Shield was strongly opposed to any legislation which would permit the Federal employee to select a program of basic coverage from one source, and impose upon him major medical insurance obtained through another source. "It is in the best interest of the employee, the Government, and the insurer that the health care services which each employee procures be obtained through a single source," Dr. Stubbs said.

Dr. Stubbs further suggested that the proposed bill "be changed with respect to that section which limits the agencies qualified to provide major medical programs to a small handful of insurance companies and thus prohibits Blue Shield and Blue Cross Plans from creating a package of basic and major medical benefits to be offered Federal employees through a single source." And, finally, he urged that provision be made for a combination of basic and major medical coverage to be offered by any qualified carrier under the provisions of the bill.

In his testimony, Dr. Stubbs indicated that the Federal Government is the largest employer which does not now contribute to or make available by means of payroll deduction some form of health benefits for its employees. Blue Shield stands ready to provide a nationwide program of health care benefits for Government employees, Dr. Stubbs announced, and its ability to do so is readily expressed by the successful servicing of Blue Shield medical care prepayment programs for more than 40 million Americans. Among these, he concluded, are hundreds of thousands of Federal employees who are currently participating in Blue Shield programs of their own volition.

OASDI COVERAGE OF DOCTORS

The fourth House bill calling for inclusion of physicians for social security coverage was introduced by Rep. George M. Wallhauser (R., N. J.). His H.R. 7295 gives an option to doctors engaged in practice at time bill is signed into law. They could come in or stay out at their pleasure. Participation would be compulsory for physicians embarking on private practice subsequently.—W.R.M.S.

L. FERNALD FOSTER HAS PASSED

Rarely does a man appear upon any field of service who consistently exercises a completely inspiring influence on that service. This holds true in statesmanship, in education, in science, in medicine. Through the ages, we have had great names in Michigan medicine and we may well be proud of them. A few of those whose chief interests were both scientific and administrative could be mentioned and the names have significance: Donald McLean, Theodore McGraw, Victor C. Vaughn and Andrew Biddle—names that were highlights in Michigan medicine. Each man impressed himself upon the medical profession and gained the universal love and respect of all who knew him.

L. Fernald Foster, M.D.

L. Fernald Foster, M.D., in his first years of practice in Bay City, became Secretary of the Bay County Medical Society. Both he and the Society had visions of service and constructive effort. He served as Secretary for thirty-nine years. In 1936, the Michigan State Medical Society wanted a medical secretary. It had established an active lay secretary but needed the medical know-how, the medical approach, a man with the ability to talk convincingly with all doctors man to man. Dr. Foster was selected and continued in that office until his death on Wednesday, May 27, 1959.

He had a most unusual capacity for quick insight, shrewd analysis of problems affecting the medical profession and the extreme ability to expound in lucid and convincing terms. He was instrumental through suggestions or actual doing, of establishing several flourishing state and national medical organizations. When he became Secretary of the Michigan State Medical Society, the groundwork which had been going on in various places leading to the creation of a prepaid medical service program began to take shape. Very soon thereafter it was accepted by Dr. Foster and the Executive Committee of The Council for complete study, organization and establishment.

Throughout the years, Dr. Foster served on the board, but not as an active administrative officer. However, when problems developed, he was the first to appear in this section of the state or that with explanations, convincing answers and suggestions.

In 1955, he became Vice President of Michigan Medical Service and in 1956, President, having arranged to give his full time and effort to Michigan Medical Service and the Michigan State Medical Society, serving the one as President and the other as Secretary. He filled these two positions completely to the point where the profession honored and respected him for his opinion and ability, for his grasp of detail, and for his supreme devotion to what he considered the very best service which could be rendered to the doctors of Michigan and to the people of Michigan.

Fern Foster has joined the great names in medical history. To those who worked constantly with him, to those who served with him less often, a giant has passed. Every worker who was closely associated with him for many years will dedicate himself with renewed effort in an attempt to fill the void created through the passing of an irreplaceable personality.

Wilfrid Haughey, M.D.

UNPRECEDENTED PROCEDURE

Michigan Legislature Passes a Joint Resolution

Messrs. Greene and Francis of the Michigan State Legislature offered the following concurrent resolution:

Senate Concurrent Resolution No. 33

A concurrent resolution of sympathy upon the death of L. Fernald Foster, M.D.

WHEREAS, The Michigan Legislature is saddened to learn of the death of Dr. L. Fernald Foster, in Detroit's Harper Hospital, on May 27, 1959; and

WHEREAS, L. Fernald Foster, a pre-eminent physician for approximately forty years, was a medical statesman, known nationally for his service to the medical profession in helping to shape its policies; and

WHEREAS, One of the founders of Blue Shield, a member of its Board of Directors since its inception in 1939, he became President of the Michigan Medical Service in 1956 and was appointed Medical Administrator in March, 1957. In 1936 Dr. Foster was chosen Secretary of the Society and re-elected annually for twenty-three years, and his work with the Society included activity with nearly every committee and project. Through his efforts many programs were inaugurated which are now accepted as standard parts of health services in Michigan and throughout the nation; and

WHEREAS, Dr. Foster's career was indeed a series of highlights: He helped to found the Michigan Heart Association and served as its first secretary. He began the Michigan Rheumatic Fever Control program while serving as a member of the Board of Directors of the Michigan Society for Crippled Children and Adults. He aided in organizing the National Conference on Medical Service and served as its President; and

WHEREAS, Dr. Foster's indefatigable energies encompassed fire fighting as well, and he was an authority on fire-fighting equipment and installations, and was an affiliate of many organizations in the field of medicine and also service and fraternal groups; now therefore be it

RESOLVED BY THE SENATE (the House of Representatives concurring), That the Michigan Legislature express its sorrow upon the death of an honored, respected and beloved gentleman, Dr. L. Fernald Foster, and extend sincere condolence to his family and multitude of friends; and be it further

RESOLVED, That a copy of this resolution be transmitted to Dr. Foster's family at their home, 787 Harcourt Road, Grosse Pointe Park, Michigan.

Pending the order that under Rule 33, the concurrent resolution be referred to the Committee on Senate Business, Mr. Hutchinson moved that Rule 33 be suspended.

The motion prevailed, three-fifths of the Senators present voting therefor.

The concurrent resolution was then considered and adopted by a unanimous standing vote of the Senate.

(Further information concerning Doctor Foster will appear in the July number.)

But Life is sweet, though all that makes it sweet
Lessens like sound of friend's departing feet;
And Death is beautiful as feet of friend
Coming with welcome at our journey's end.

—GEORGE WILLIAM CURTIS

Open Forum on Prepayment Hospital and Medical Care Plans

THE great strides medical science has made in the past fifty years—unquestionably the greatest clinical progress in the long history of medicine—have made public interest in medicine and personal health second to none in the realm of science. That includes nuclear fission, sputnik and moon shots.

A recent University of Michigan survey on newspaper and magazine reader interest and reader retention showed that the general category of Science ranked very high—third from the top of all subjects. And most significantly, within that science category, interest in news about health and medicine outstripped all others.

Although the survey experts had a pretty good idea that public interest in health was high, even they were surprised at the results of a hypothetical question given participants. It asked, in effect, if funds were available for basic research, missile and satellite research, juvenile delinquency and for health and medical research, which should get top priority?

The overwhelming choice was health and medical research, with moon-trips—seemingly more glamorous and appealing to the public imagination—coming in far behind. About 54 per cent chose medical research, 32 per cent juvenile delinquency and 7 per cent basic research.

Hand-in-hand with this tremendous and continuing interest of the public in medicine and health is the interest in the problem of financing this better, more complex, more costly medical care.

Prepaid hospital and medical care—born in Michigan with the creation of Blue Cross and Blue Shield some twenty-five years ago—is obviously here to stay in one form or another. New developments in medicine, in hospital care and hospital use, a greater public awareness of the value of health care—all these have combined, however, to continually raise new problems in coverage under prepayment.

The practice of medicine itself should always remain solely in the hands of the medical profession.

But the financing of medical care has truly become a problem in which a great many segments of society have a legitimate stake and a legitimate interest. This includes organized medicine, the public, including organized labor, Blue Cross, Blue Shield and the commercial health insurance field.

To provide an open forum for the admittedly divergent views of these segments, The University of Michigan Bureau of Hospital Administration of the School of Business Administration sponsored a one-and-one-half day Institute for Hospital Administrators, April 2-3, 1959, at the University.

Its expressed purpose was "to provide an open forum for those interested in payment of and those rendering hospital and medical services. To examine through formal presentations and group discussion, problems involved, how gaps can be closed and the relative roles of selected agencies."

Participants included leaders in the field of medicine, hospitals, management, organized labor, Blue Cross and the commercial insurance field.

As one of the participants, in describing the importance of such institutes, put it:

> "We have now reached a point where all the parties who are essentially for finding improved methods of financing health care and do have a real intrinsic and unalterable interest in this are together. It's going to make life very difficult for us in the years ahead, but it offers us an invaluable vehicle that can be harmonized with the best of modern medicine that can help free the physician, the hospital and the patient of economic barriers and help provide and obtain the kind of care that is dictated by the standards of our expanding medical knowledge."

To provide you with an insight into what leading spokesmen in medicine, management, labor, Blue Cross and commercial health insurance are thinking, we present on the following pages condensed versions of the formal presentations of the various speakers at this open forum institute. You may disagree with some or all of their presentations. But whether you agree or not, you will probably come away from the reading better informed as to what these segments of society believe the problems and possible solutions to prepaid health care are. And from a knowledge of their thinking, you will undoubtedly crystallize and strengthen—or perhaps even alter—you own convictions.

Labor Views Financing of Hospital and Medical Care

By Jerome Pollack
Detroit, Michigan

THE gathering of labor, management, hospital, medical and prepayment representatives to discuss their common problems in financing health care is still a rather new and welcome phenomenon. Before launching into the distinctive views and needs of labor, we would do well to appreciate the growth of common interest among these different groups that has made it possible for them to join in programs for financing health care that now serve a majority of the population.

Until very recently, there were wide disparities in the health of people, according to their income, occupation and station in life. The mortality of unskilled workers, for example, according to studies made in the thirties, was about twice that of professional men. People with lower income suffered higher mortality from nearly all of the principal causes of death. They had a greater prevalence of illness and a much greater volume of untreated symptoms, a finding that still remains today, even though the gaps by income and socioeconomic status have been reduced.

The early programs to finance health care for workers faced problems distinctively different from the latter-day prepayment plans serving the general population. They were designed to serve people with substantial health needs and modest means. Their primary purpose was to prevent economic barriers from standing in the way of needed care—an objective that we sometimes lose sight of today. Everyday health care came first. Protection against financial ruin was the product of more affluent times. The arrangements to provide care were almost as important as the financial aid in paying for it.

For a long time, these early programs that go back about a century stood almost alone as outposts of prepaid health protection in our country. The report of the AMA's Commission on Medical Care Plans is in a sense a tribute to some of these earlier plans. Only with the substantial elevation in the health status of workers, which has accompanied a general upgrading in status and standards of living, has it become feasible to join, as we now have, in common programs for financing health care that cover a majority of the population. From a special problem, the health of the worker is becoming increasingly a general health problem. The people who comprise labor now receive most of their care from the same hospitals and the same physicians as the rest of the community and are faced with similar problems in financing their care. If there is one new and important trend in labor thinking about hospital and medical care, it is towards greater participation in community programs for financing health care, and towards a greater identity of interest.

Mr. Pollack is Program Consultant, Social Security Department, UAW.

New Form

When general health insurance spread to a majority of the population, it took an entirely different form and had an entirely different motivation from the plans that had specialized in protection for workers. More than anything else, the deep financial crisis that existed in all phases of health care in the early thirties precipitated action on health insurance. In the four years following 1929, consumer expenditures for personal health care dropped by a third. Payments to physicians fell 36 per cent. Occupancy rates in the voluntary hospitals were hovering around 55 per cent.

In a volume entitled "The Crisis in Hospital Finance," published in 1932, Michael Davis and Rufus Rorem concluded:

> "If American hospitals are to be financed by patients' payment in the future, even as much as they were in 1929, these payments must be made more assured and more stable. The life of voluntary hospitals is threatened because of the instability and unevenness of this major source of income."

The President of the American Hospital Association was quoted as saying:

> "Without being pessimistic as to the future, the American Hospital Association would be unmindful of

the members' interest if it did not recognize the possible breakdown of the voluntary hospital system in America. . . ."

This was the moving force that brought prepayment to most of America. It was not an attempt to invent a better mouse trap with 121,000,000 people beating a path to the door. It was an effort to keep the roof from falling in.

Medical societies, fearing that legislation on a national health program was imminent, were spurred into adopting plans of their own in the hope that they would avert such legislation. Private insurance companies entered the field with similar sentiments.

Voluntary health insurance left the ground like a rocket. When last sighted it had passed the four billion dollar mark, already reaching a fantastic size, and now, although everyone seems to think it's off course, it's still rising very, very rapidly.

Probably there is no parallel in American life to this surge of enrollment in which more than 80,000,000 people were newly covered by voluntary health insurance in the decade following World War II. Sweeping changes in the economy made it possible for people to afford protection. Millions left the depression tired of charity wards where occupancy rates were running at 100 per cent. They wanted to be able to afford semi-private accommodations; they had had enough of not being able to pay their medical bills, and were anxious to be able to do what they could to pay in the future. They were willing to contribute directly and to allocate gains in collective bargaining for health insurance.

Getting off the ground was an extremely important development. Obviously, four billion dollars worth of health care a year—and it's still growing—does a monumental amount of good. But, as we so often read in the papers these days, important as a launching is, it is not enough. Whether health insurance has gone into orbit is still a question.

We know that the growth of voluntary health insurance, faced with its intrinsic needs, has been very shallow. Earlier estimates, modest as they were, have actually over-stated the depth of protection. Corrections in the 1958 Survey of Current Business show that this year health insurance will cover only about one-fourth of America's total private health care bill, a little more than half of private hospital care, and perhaps 30 per cent of physicians' services.

The protection remains addressed overwhelmingly to hospitalized illness and to surgical care. In spite of the tremendous growth, the average insured family probably still has uninsured about twice as much of its total personal health care, as it has covered.

There is room for legitimate argument about how far prepayment can and ought to go toward covering all of health care. But there is no question that it was ever destined to stop at its present level. Judging from its past rate of development and from the needs that remain unsatisfied, prepayment can reasonably be expected to double in volume within the next five to ten years, and to cover, perhaps, two-thirds of the average family's expenditure for health care.

Evolutionary Course

This is a modest expectation. It assumes an evolutionary course of development and does not strain the upper limits of insurability. Those plans that have already gone further toward achieving this level—such as the Windsor Medical Plan in Ontario, H.I.P. in New York, the Kaiser Foundation Health Plan—make it abundantly clear that the present struggles of people to meet the uninsured costs of care are largely an unnecessary privation. But how to achieve more comprehensive protection is an open and much disputed question.

The quest for more inclusive care is not advanced solely by labor. Much of the impetus, in fact, has come from management personnel dissatisfied with their own protection, impatient with the inadequacy of benefits limited to hospitalized illness and seeking to protect themselves against financial ruin. Major medical insurance is essentially a management revolt against these deficiencies in health insurance. For a time, major medical insurance dominated the scene. It was proclaimed that health insurance had started at the wrong end and was proceeding in the wrong direction. And most appealing to those distressed by rising costs, the deductible and co-insurance provisions were expected to check the rise in cost.

Labor was worried about the Davy Crockett stage of major medical insurance. The resurgence of economic barriers to care was directly contrary to the original aims and whole direction of health insurance. It was one thing to accept gaps in protection that represented areas of coverage that hadn't yet been reached. It was quite another thing to see economic barriers deliberately reim-

posed and to hear a lot of the nonmedical talk about the unimportance of small claims, a convenient fiction— that might be rather nice if it were true—but there is no demonstrated evidence that care involving a small expenditure is necessarily medically unimportant.

Catastrophic care needs attention. It is a legitimate concern of prepayment. But the worker is less concerned with protecting himself against financial ruin. He wants and he needs service benefits. He wants (and this was recently confirmed by the Opinion Survey made by the Michigan State Medical Society) coverage of minor as well as major conditions; and he continues to be concerned with the availability and accessibility of care more than with the threat that illness may wipe out his nest egg.

The magic of major medical is now largely dispelled. While some went on to embrace the hula hoop, others are returning to sanity, and realizing that no simple trick like co-insurance and deductible will solve the essential problems that face prepayment. Mounting losses on major medical insurance have dampened hopes that it would neatly control costs. It, too, has been susceptible to one round of rate increases after another. In fact, its cost has shown less stability than hospitalization service plans. And so we return without any panacea to the difficult problems of extending health insurance into new segments of care which are inherently more difficult to insure and that will require far more effective controls than now exist. For voluntary health insurance to double in scope without better controls than it now has is to court ruin, not from without, but from within.

Constructive Critic

Labor has been an active critic, but it is not the principal adversary to voluntary health insurance. Originally a moving force in favor of legislation, labor has become one of the most constructive and sustaining forces for voluntary health insurance. This may sound paradoxical, but it has the virtue of being true. Labor's acceptance is by no means uncritical, as you know, nor has it relinquished its intrinsic right to press for legislation if need be. But in so vital a field, the need for timely protection is paramount and supersedes the form that may be taken. Although labor continues to be portrayed as a threat, its actual record has been one of support for voluntary health insurance. Labor began to purchase prepaid health care even before substantial employer contributions were in prospect. Often it had to insist on the right of payroll deductions for this purpose. As negotiations came to include health insurance, through continued efforts to obtain better protection, labor has supported voluntary health insurance and helped give it a favorable climate in which to grow.

But the position that anything will do just so long as it is voluntary has also become untenable. Opposition to national health insurance is not enough. The coalition that came together to avert legislation is now largely divided on how the voluntary system should operate and even over what its aims should be. Ultimately, the greatest adjustment has to be made by those who, in opposing a legislative program, were not for a voluntary one and are still not ready to make voluntary health insurance work.

The most serious deficiency in form is the widespread use of indemnity benefits which pay a fixed amount, regardless of how much the care actually cost. As the insured must pay the full cost which has no predetermined ceiling, indemnity benefits at best offer uncertain protection. Moreover, in a transaction where fees are set traditionally according to ability to pay, they are further impaired by an intrinsic susceptibility to misinterpretation and abuse. In a futile attempt to keep up with fees, indemnity fee schedules have been raised from the once standard $150 maximum scale to $200, $225, $250, $300, $400, $450 and even more. It is perfectly true that many of these schedules were never negotiated with medical societies and that physicians are free to charge more. It is true that there are many inequities and deficiencies in these schedules. But it is also true, and supported by abundant evidence, that indemnity benefits on the whole do not get the same weight as out-of-pocket payments. The indemnity form is defective. Who would buy life or fire insurance if the cost of living to survivors, or to rebuild a house, were predictably higher because the people had gone to the expense of insuring themselves? The deep dissatisfaction arising out of indemnity dealings is harming the prestige of the medical profession beyond the power of public relations to set aright. If health insurance is to continue to prosper, it must assure its subscribers that a dollar paid by insurance buys the same protection as a dollar paid by the patient.

It is not going to be easy for hospital prepayment plans to find their place in the surge for more com-

prehensive coverage. While it is entirely understandable that plans sponsored by hospitals are inclined to stop with hospitalized care, and while it is indeed difficult for them to proceed further, there is no question that in the interest of properly designed adequate health insurance plans, it is necessary to go far beyond the hospitalized illness. The prepayment plans operated by hospital associations have shown great leadership in fighting for service benefits, community rating and in many of the innovations they made in the years when it was they who largely shaped health care. Recently they have been taunted with lack of leadership, for their slowness in moving toward more inclusive care. The real challenge to such plans is in the question whether they were not primarily designed to solve the financial crisis that existed in the early thirties in hospital financing and that, having largely solved this crisis, they are not disposed to go further. This is not a taunt: If the hospitals do not go further; if they abandon their own goals of becoming community health centers providing extensive care for ambulatory patients, and serving as a base for medical practice, research and education; then they have to assume a declining role in prepayment as it grows in scope.

Honeymoon Is Over

In spite of its dire beginnings, voluntary health insurance has spent most of its career in the flush of post-war affluence, when people were only too anxious to have a vehicle through which they could pay for care; when they were not especially concerned with premiums and only too glad to be able to pay them. Now, however, people are concerned about the impact of prepayment on the cost of care.

There are legitimate grounds for such concern. To raise the issue, is not necessarily an attempt to find scandals. Medical care in America is in the throes of profound technologic and economic change. Undeniably, there is a great advance in medical knowledge. Undeniably, procedures are today commonplace that were unknown ten to twenty years ago. Undeniably, more progress has been made in certain aspects of medicine in recent decades than in previous centuries. There are indications that the volume of doctors' visits for the average person has almost doubled in recent years. The demand for service has been compounded by a population that has been growing much faster than had earlier been supposed. Moreover, rapidly growing and rather immature health insurance plans are exerting profound pressures on the financing of private health services for which they were not nearly prepared. All of these changes pose a demand for service and challenge the capacity and organization of medical care and the methods of financing as never before in America.

But even after recognizing the many acceptable explanations, the increases in cost still remain a matter of real public concern.

Requests for rate increases by Blue Cross Plans are being met with hearings. Labor may be conspicuous in such hearings, but the concern of the public is far more general. A rather stern adjudication by the Pennsylvania Insurance Commissioner raises the question whether insurance hasn't unnecessarily inflated the cost of care and whether the public interest is adequately protected under plans originated and still dominated by the purveyors of service. Investigations are being conducted in Michigan, New York, Pennsylvania and elsewhere. Fortunately, these studies are being made by competent professional groups with broad public sponsorship. Perhaps they will find some of the answers to these very difficult questions.

Consumer resistance to the increasing cost of health insurance is still new. Thus far, there has been a tendency to regard any resistance of a rate increase or an objection to the amount requested as destructive, sometimes as a threat to the hospitals or physicians. Medical societies have been particularly reluctant to negotiate over fee schedules with consumer groups, many in their ranks feeling that consumers should have no involvement whatsoever in setting fees, even in consultation and through negotiations with the medical societies. As a result, many such plans have presented their offerings to the public on a take-it or leave-it basis. If the hospitals and physicians regard their respective plans as their own property and conceive of the prepayment plan as their agent, then the consumer is bound to regard the plan on an across-the-counter basis.

But prepayment is far too important, both to the consumer and to the provider of service, for this arms' length dealing.

Labor is going to continue to co-operate with voluntary health insurance plans that we now have and continue to work for their improvement. Plans of the M-75 variety in our state are a great step forward in affirming service, in extending the scope of medical benefits, and in setting up medical

review committees under the sponsorship of the medical society. But much more is needed and it is disconcerting to see the reluctance of medical societies in other areas to accept even these gains. A humbling example of how much further such plans of this basic type can go—sponsored by medical societies and offering free choice of physician—is to be found in the nearby Windsor Medical Service.

Labor is also going to continue to work for more comprehensive direct service group practice plans. The primary reason has been the failure thus far to get more comprehensive protection, the failure in many areas to get service rather than indemnity benefits, the drifting of the non-profit plans away from community rating. The last straw was labor's realization that if it did not act, it would have to accept the retreat to co-insurance and deductible provisions, and to economically-oriented rather than medically-oriented plans.

Out of this dissatisfaction, labor groups have been increasingly stimulated in recent years to develop their own programs. Labor people have seen at first hand that it is possible to have more comprehensive benefits. Labor is impressed with the promise of group practice and feels strongly that it ought to be given a chance to develop, unimpeded, and to demonstrate what it can do in competition with all the other forms of practice.

The basic pattern of labor thinking, however, is toward community plans rather than away from them. The directly operated labor health centers are attempting to broaden their scope and serve more than the members of a single union. Some are looking at the community as a whole. In Michigan, the United Auto Workers made a careful and deliberate decision to support a community plan rather than to build one solely for its own membership. The Union concluded that the community was essentially more dedicated to the quality of care and most concerned with the end product of health care than any of the other parties alone.

Labor is increasingly committed to dual choice of plans, in which each individual in the group may elect either a closed panel plan or one offering free choice. Where each individual is given such a choice, the one who choses a panel of doctors makes every bit as deliberate and informed a choice as the one who chooses an individual practitioner.

There are encouraging signs that earlier efforts to crush the independent direct service plans are on their way to becoming a closed, if unedifying, chapter of medical history. This is all to the good. For, in time, organized medicine is bound to offer hospitality within its ranks for plans employing different principles of organization and reimbursement, provided that they offer good care. How far and how fast such programs will grow will depend on what the general health prepayment plans will do. It is largely a matter of competition in the American tradition.

New Responsibilities

Thus far, health insurance has proceeded on the premise that its responsibility is largely limited to reimbursement for care. There has been a scattering of efforts to influence the quality of care under prepayment. But generally, the effort has been made to draw a sharp line between financing and care. Even where this was the intention, the separation between prepayment and practice has actually proved to be impossible. Prepayment does influence practice. It can put people into a hospital. It can influence how long they stay. It can encourage surgery. It can affect the choice of hospital, of physician or of a group of physicians. It can advance or retard the timing of care. These influences go on whether they are understood or not, recognized or not. If not understood, or if ignored, they can encourage bad practice; if recognized and constructively applied, they can encourage good practice.

Health insurance can succeed only to the degree that it secures the active participation and support of the medical profession. That is why the successful examples to date have been those with active medical participation, even when the plans have been in official disfavor with the rest of the profession. Large segments of the profession, however, have not given health insurance, even in its voluntary form and even under medical society sponsorship, the support it needs. A great many physicians shy away from these matters. Many are too busy. Some are still hostile. And prepayment is not getting the medical attention that it needs.

Yet a properly designed system of prepayment, with any real chance of survival, can be devised only out of a deep understanding of medical care. Second hand actuarial theories derived from life and casualty insurance will not do. These coverages evolved their own theories. Health care—the

most complicated contingency to which insurance has ever been applied—will in turn need its own. The commonly cited analogy between automobile collision and health insurance is so inappropriate and unmedical that when fully explored, it generally proves intolerable. Health insurance will not be abe to ride piggy-back on other coverages. It will have to live by its own lights.

Medicine should attempt to do for health insurance what it has done for medical education and in improving the standards of practice. The economic fate of the medical profession is now irretrievably tied to health insurance. Health insurance is not going to be turned back. The only alternative to its further expansion and improvement will be some other social method of financing and distributing cost. The burden will never again fall solely on the afflicted.

Prepayment has brought the physician, the hospital and the patient closer together than ever before. It has brought new parties into the relationship—the prepayment plan, the employer, the union and the public. It has thrown them together into new and intimate relations for which none of the parties were prepared. All have been faced with bewildering and, at times, almost overpowering problems. After all, the purchase of health care by people who are well is on an entirely different footing from the purchases by those who are sick. The change is profound. How little it is understood is revealed by much of the castigation of "Third Party" payments. The critical issues today are whether prepayment will be able to grow in comprehensiveness; whether it will be able to devise satisfactory forms of protection; whether it will be able to assure value and quality for the monies expended; whether a voluntary system composed of hundreds of separate plans sponsored by hospital associations, medical societies, commercial insurance companies, consumer groups, labor, industry and others—with authority spread over a great number of hospitals, hospital associations, physicians, medical societies, medical groups, dentists, optometrists and other professions; employers, unions welfare funds, consultants, insurance commissioners and still others—can meet the reasonable needs of society for prepaid health care or whether at some point it will break down as a tower of Babel, unable to reconcile the many voices and interests. Prepayment, however, has brought together the parties essential for finding improved methods of financing care, and who have an intrinsic and unalterable interest in the care rendered. Unquestionably, it is going to make life difficult in many ways in the years ahead. But it offers promise of an invaluable vehicle that can be harmonized with the best of modern medicine, that can help free the physician, the hospital and the patient of economic barriers in ordering, providing and obtaining the kind of care which is dictated by medical necessity and determined by the standards of our expanding medical knowledge.

Management Views Financing of Hospital and Medical Care

By Malcolm L. Denise
Dearborn, Michigan

MANAGEMENT of the modern corporation has an interest in the subject of hospital and medical care, both in its capacity as an employer of people to man its facilities and in its capacity as an industrial citizen of the communities in which it lives and does business.

Over the past couple of decades, there has been increasing awareness by corporate management of its responsibilities in both capacities. I know there have been great developments on both scores at Ford since 1946.

We come into direct contact with this problem of hospital and medical care in several ways, of which the most direct are these:

1. As the operator of our own plant medical facilities and services.

2. As a donor and solicitor of employe donations towards meeting costs of community health programs and facilities—both operating costs and capital expenditures.

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3. As a purchaser of hospital and medical services for employes.

The first of these has probably the least bearing on our discussion here today, and I shall not dwell upon it.

The other two phases of our relationship to medical care problems—as a supporter of voluntary community agencies and, jointly with our employes, as a customer—are more relevant to the subject you are examining.

The development of proper and intelligent management attitudes, policies and actions with respect to both of them is considerably more involved and difficult. Management must relate them to a number of considerations, and attempt to reach specific solutions to the problems confronting it which reflect a sound, realistic application and balancing of these considerations.

What are these considerations? There are several which seem to me of great importance.

I would list as perhaps the most basic our stake in the preservation of a free society and a free economy in America. The individual freedom which we Americans have been able to enjoy has been made possible by a system of institutions which has accommodated an unprecedented degree of diversity and autonomy within an over-all unity. This has released the energies and ingenuity of our people to accomplish—voluntarily and largely without the compulsion of master planning and state control—the highest standard of living for the many that man has ever known.

Important Role

It is, of course, a truism that freedom is inseparable from responsibility.

One corollary to this broad consideration is that medicine and medical services must be able to attract and retain able people voluntarily, in competition with other callings and vocations. We live in a world of limited choice. We can either attract people or we can conscript them, and if we are forced to resort to conscription, freedom dies.

Secondly, management must never lose sight of the role which it should play in a free society. Generally speaking, management is interested in advancing the well-being of its employes and the communities in which it operates. But its responsibilities cannot end there—it has equal responsibility to consider the interest of customers, stockholders, and the public at large. No matter how high our motives or how deep our desire to improve conditions of employment or in the community, there is simply no escape from the proposition that wages and benefits and contributions are costs of production. Our economic system relies on management to control costs. If management fails in that duty—if it does not keep the costs of doing business at a level which enables the business itself to grow and prosper—then it fails utterly in its responsibility to customers, stockholders, public, community, and employes alike.

This, quite simply, means that the desirability or alleged need—which is, really, a relative term—of some particular health project or program cannot be the sole or overriding criterion for management decision. It is one of the harsh, inescapable facts of human life that we cannot have more than we can afford; and if we attempt to do so in one area, we pay the penalty in another, regardless of how we organize our society.

The importance of considering the cost factor in developing policies in the medical care area is doubly emphasized by a look at what has been happening to the cost of medical care itself.

According to the Health Information Foundation, the personal expenditures of the American people for their health care in 1957 added up to more than 15 billion dollars. This is only the amount we spent privately—on hospitals, doctors, dentists, drugs, glasses and all the other things we use in our health care.

This 15-billion-dollar-figure does not tell the whole story. It represents only personal expenditures. We must also add the huge sums of money spent on health care by federal, state, county and city governments, by our charities and philanthropies, and by business and industry on industrial health clinics. When we include the money spent in these categories, the total estimated sum for 1957 becomes 20 billion dollars.

Even this 20 billion dollars does not cover the whole bill. It does not, for example, include public and government funds spent on medical research or on the construction, expansion and equipment of hospitals. Nor does it include the administrative and other costs incurred by employers for the health care insurance plans tens of thousands of enterprises provide their employes. Our experts tell me that if we added these amounts to the 20 billion dollars, the total probably would equal about half of this fiscal year's proposed budget for defense.

The figure is impressive. Even more significant

to our thinking than the total sum, however, is the rate of increase. The 20 billion dollars known cost of heath care last year is double the corresponding figure for ten years ago, and five times the figure for twenty years ago.

We see no basis for confident prediction that medical costs will level off in the near future. On the contrary, there is every reason to believe that they will continue to rise.

The rate of innovation in medical science and medical practice is rapid and promises to become even more rapid in some areas. As medical practice advances, the hospitals must keep up with it. Hence, it is reasonable to suppose that the rate of change and obsolescence in hospitals will be greatly accelerated in the next decade.

Moreover, it seems likely that we shall continue to use more and more hospital and medical services. This is a guess, I know, but it is based on experience. Between 1935 and 1957, annual hospital admissions per 1,000 population increased from 59 to about 130—and the curve is still rising. There is no evidence that the rate of use will diminish or level off. It seems much more likely to increase. What these facts signify for hospital costs—both capital and operating expenditures—is almost immediately apparent. For one thing, the need for highly trained personnel will increase and competition for these people may become more acute and costly. For another, it is very likely that inflation will continue to affect the cost of all the things that a hospital needs.

Crux of Problem

In this connection, I would like to come back to the proposition that real improvements in the standards of our people as a whole can come about only by increasing our efficiency and productivity—in other words, by increasing our output per unit of the resources at our disposal. And, insofar as I am able to understand them, our commonly used measuring sticks are particularly ill adapted to arrive at meaningful conclusions as to the productivity progress in professional and service fields such as health and medical care. But one thing seems clear—to the extent that our health and medical programs do not increase their own efficiency, they can progress only at the expense of other needs and wants of our people.

The final consideration I would like to mention is this: There is a definite management self-interest in the continuing good health of employes. We know that proper care in the event of illness or accident can insure an earlier return to work, and can be a major factor in the efficient operation of the company. We know that a major share of absenteeism is caused by off-the-job illness and accidents. We have to schedule for it, make allowances for it, transfer employes to unfamiliar jobs with resultant loss of efficiency. Moreover, as management problems and industrial processes become more complex, we become increasingly dependent upon highly skilled people. The absence of just a few key people can be very costly to us. In our own self-interest it is important that our employes be healthy and productive.

At the same time, it must be acknowledged that to date no one, so far as I know, has come up with a satisfactory price tag on factors such as these which would enable management to determine the dimensions of cost expenditures for medical benefits which actually are recouped through such factors. It is doubtful, in my opinion, that the nature of the situation is such that reasonably precise calculations of this kind are possible.

Now, all of these considerations that I have discussed are not always easy for mere fallible humans —which managers, after all, are—to bring into a proper balance when deciding upon specific proposals for management policies and actions; but decisions nevertheless must be made.

Management's Role

I would like to discuss, in the time remaining, some conclusions to which these considerations have led us in the company I represent.

First, let's consider our role as an industrial citizen of the community, concerned with the support of community health agencies and facilities.

As a major employer, we must dispose of requests for direct contributions to innumerable voluntary agencies in this field, and to requests that we permit, undertake, administer or otherwise support appeals to our employes for contributions to such agencies.

There seems to be no natural limit to the number of groups which can form themselves for apparently worthy purposes and undertake fund drives. For the individual employer to pick and choose intelligently without risking ill-feeling, charges of favoritism and discrimination, and wasteful or unwise use of donated funds is a virtually impossible task.

As a step toward solution of these and related

problems, we endorsed the United Fund approach at its inception, and took an active part in its development.

As you probably know, ten years ago Detroit pioneered the United Foundation, and after ten years' experience we are absolutely sold on it. Year after year, it has proved to be the simplest, most cenvenient and most economical way of doing the job for which it was designed.

We were active in developing a comparable approach to the raising of capital funds for community facilities—chiefly hospitals.

But, as we see it, the greatest selling feature of federated giving from this time onward will not be mere convenience. It will be the evidence that federation gives of thorough planning which enables it to provide all the health services a community should provide. Federation has moved beyond the stage of initial enthusiasm. It now has adult responsibilities. It will continue to enjoy success only insofar as it measures up to these responsibilities. It will maintain its place only as it proves itself capable of keeping up with the changes that affect community health services, and of serving the community well. If it is to continue its early success, it must be ready to adopt new attitudes, new disciplines and new habits of thought about community services. Above all, it must plan programs with all the care it can muster.

And here, of course, the problem of rising medical costs confronts us head-on. We see this economic problem as one of the gravest difficulties lying ahead for federation. If we are to continue our voluntary United way of handling community health problems, then we must prepare for a possible doubling of the cost of health services in the next ten years. And unless we demonstrate our ability to cope with rising costs in such a way that the community's health needs are adequately served, and for adjusting community programs to changing community patterns, then federation as we know it seems doomed.

Our voluntary community health services, including our voluntary community hospitals, have throughout our nation's history provided us with a way of dealing with our health needs that is consistent with our democratic and free enterprise society. This tradition of self-help through the neighborly sharing of our common responsibilities is part of our way of doing things. It is the medium through which the employer can best meet his responsibilities in this area as an industrial citizen of the community. It gives him the opportunity to contribute to the group effort, not only his money, but the specialized talents and knowledge that experienced business management can contribute toward realistic planning and administration, the avoidance of waste, and the necessity of living within the means available. And at the same time it preserves to the professionals and experts in the field of health and medical care primary responsibility for the design and execution of their programs, and provides a mechanism for resolving the often competing claims of the various interests which make up the community.

In our capacity as a "consumer" of medical services through contributions toward the cost of selected hospital-medical care benefits for our employes, we are not over in a separate compartment completely walled off from that labeled "community citizenship." On the contrary, in the consideration of such programs we have kept very much in mind their relationship to and impact on the community.

Thus we have opposed the notion of special facilities and medical programs designed for the exclusive use of our own employes or the employes represented by a particular union or group of unions.

Michigan Standard

Our principal employe coverage for basic hospital-surgical protection is through Blue Cross-Blue Shield plans. Our employes are enrolled under more than 40 of these local Blue Cross-Blue Shield plans.

We attempt to select from the coverages available at each location that which provides the most nearly uniform protection for all our employes. Our standard is the Michigan Blue Cross Comprehensive Plan and Michigan Blue Shield's M-75 program.

Since Blue Cross-Blue Shield plans are local organizations, the plans which they develop are designed to meet local needs and are influenced by local considerations. In many instances, local Blue Cross-Blue Shield organizations, especially Blue Shield, have not offered plans as comprehensive as Michigan Blue Cross-Blue Shield.

About 70 per cent of our hourly employes now have coverage that is equal to or close to the Michigan standard. It is not our policy to pressure local Blue Cross-Blue Shield organizations to devise plans that are facsimiles of Michigan Blue

Cross-Blue Shield. We recognize that local conditions differ. However, through Michigan Blue Cross-Blue Shield which is our Host Plan, we do let other Blue Cross-Blue Shield plans know that we are ready to accept coverage that is consistent with the levels set forth in our bargaining agreement wherever such plans are made available *to the community as a whole*. We firmly believe that any attempt to secure an exclusively Ford contract could result in an undermining of the community approach.

Consistently with the considerations discussed earlier, these coverages are offered employes on a voluntary and contributory basis. Over 90 per cent of our employes have elected to participate in them.

The costs, to both company and employes, have risen steadily ever since we adopted such plans, and promise to continue to do so. The increases are attributable in part to improvements in the coverages themselves, and in part to the increased costs of providing the services covered. These costs have become a very considerable item in the total labor costs that must be reflected and recovered in the prices of our products.

The increasing cost of providing the covered services gives us particular concern because it is largely beyond our own control.

We could, to be sure, achieve better control of our own costs by going to indemnity-type plans. But, so far, we are not convinced that, in this field, indemnity plans give as good *value* for the money expended as do prepayment service-type hospital and surgical plans. This, coupled with our interest in community programs, has influenced us against embracing the indemnity route to date.

It has been charged that our present system, and, in particular, the service-type prepayment plans, furnish insufficient incentives for reasonable cost controls. We do not subscribe to this. If nothing else, the ever-present pressure for socialization of hospital and medical practice and care should provide incentive enough.

Keeping hospital and medical care costs under effective control should be the constant goal of hospital administrators and the medical profession. Theirs is the primary responsibility, and theirs is the competency to do so without sacrifice of medical standards and the traditional ethics and freedoms of their callings. As customers interested in value received, employers have a responsibility to see that the consumers' needs and interests are accorded real weight. As citizens, businessmen have the responsibility to see that they support only programs that merit their support, and to contribute such advice and know-how as falls within their special competency. But, ultimately, the job can be done only from inside.

At the point where we are negotiating with unions concerning our employe insurance programs, we are fully conscious of the impact that our decisions and actions could have on medical and hospital practice. Because we are aware of this potential impact, however, we have been especially careful to give weight to all of the various considerations I have mentioned in developing the positions we take and the propositions we make in collective bargaining.

The fact is, we and our major union, the UAW, have, simultaneously, a certain common interest and what appear to me to be some distinct differences in ideology and approach when we bargain on these matters.

We have in common, of course, an interest in selecting good insurance or prepayment arrangements at good values for our employes.

Where We Differ

I think we differ, however, on the role that collective bargaining should play in shaping hospital and medical practice as such, and in solving broad community problems. The UAW quite regularly seeks, through bargaining pressure, to force our aid in implementing its social or community objectives. We, on the other hand, have a deep conviction that the collective bargaining arena, designed to resolve labor-management differences over conditions of employment, is one of the most ill-fitted places conceivable for resolving these other kinds of problems. If they were to be permitted to become entangled in the considerations for maintaining labor peace in our plants, it would be bad—both for us and the community.

There is another difference, I think, which runs much deeper. It has to do with our respective attitudes toward the proper role of government, the responsibility of the individual, and the values in our free institutions and traditions. Thus we part company with the UAW with respect to its attitude toward our existing systems and institutions for providing care. We know they can stand improvement, like most other things in this world, but we do not view them as anti-social. And we disassociate ourselves completely from what fre-

quently appears to us to be its war against the medical societies.

To conclude, I have faith in voluntary programs and the ability of the professions and community organizations involved to fulfill the needs of our people.

I am encouraged in this faith by the increasingly abundant evidence that our doctors, our hospitals and our voluntary community organizations are conscious of the problems, aware of their responsibilities and actively seeking better ways and means of meeting them. Given this awareness and attitude, I feel confident that they will be met within the framework of our free institutions.

Hospitals View Financing of Hospital and Medical Care

By George E. Cartmill, Jr.
Detroit, Michigan

THE HOSPITAL'S view of the financing of hospital care has been very much influenced by one special consideration which I think we do not actually come out and state, usually. It involves the question of whether or not the hospitals have a right, considering their basic obligation to the community, to become deeply involved with the problems of financing hospital care.

The thought behind this consideration may be stated in two parts:

1. It is the basic obligation of the hospitals to provide their patients at all times with services of the highest quality, and with whatever care is prescribed for them, regardless of cost.
2. It is up to the patients, individually or collectively, to make sure that the money will be there to pay for these services when they need them.

Unless these two problems are kept separate, it is feared that the economics of financing may dangerously begin to influence the quality of hospital care.

This fundamental consideration in the hospital's view of the problem of financing hospital care has recently been rendered more or less academic by Blue Cross events, the length and breadth of the country, as well as in our own State of Michigan. Blue Cross, morally and legally, must maintain reserves to safeguard the interests of both its subscribers and its member hospitals. For several reasons Blue Cross has found it necessary to set limitations on the payments which hospitals can expect to receive for the care they provide their Blue Cross patients. The price consciousness of the consumer has thus become a pre-determining factor in the operations of the hospital.

May I say here by way of interpolation, I shall not attempt at all to discuss the other limitations which have been forced on hospitals over a period of years. The notorious reluctance, for example, of governments at all levels to pay adequate reimbursement for cost of care to its wards are much too well known in this group to bear any discussion time.

This is the relatively new situation that we face today. With ceilings and limitations, the job of trying to keep a hospital within a state of some solvency these days leads one inevitably to devote a great deal of thought, and some of it may be apprehensive to the future of prepayment and how hospitals should view the problem.

Is this, perhaps, a turning point in the history of the American hospital? Are we leading into a period of budgeted operations, or let us say, hospital progress if and as we can afford it, or is this just an interlude? At this point, of course, we can only speculate.

Broad Study

The first comprehensive analysis of the whole problem of financing hospital and medical care is now being made by the University of Michigan. We are fortunate that it is being made in our state, but I think we must wait until this study is complete before we can expect to develop a new approach to the problem. We are counting on the report to clarify the picture for all of us—for or-

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ganized labor, for the public, for Blue Cross, and for hospitals—and to give us all an objective base upon which to build.

In the meantime, the best we can do is to try to answer certain questions. Has there been anything wrong so far with the hospital's view of financing of hospital care? What should we avoid? What will probably happen?

The late Prof. Lawrence Henderson of Harvard has been quoted as fixing 1912 as the first year in human history "in which the random patient, with the random disease, consulting a random physician had a better than 50-50 chance of benefiting by the encounter."

This was the year, let's say then, when medical and hospital service began to become things that people would want as aids to health and would want to make sure of having them. And looking at this year 1912, hindsight tells us that it would only be a matter of time before we would see the center of gravity in hospital economics swing decisively from the gift dollars to the consumer dollar.

The period between 1912 and World War II was one of phenomenal progress in medicine and hospital practice. The modern community hospital came of age during that time. But throughout this period, despite the changes and improvements in hospitals and the increasing number of patients they had to serve, hospitals continued to operate without excessive dependence on patient income and with traditional inattention to patient opinion in matters of policy. Income from endowments and gifts provided the backbone of hospital finances, and under this arrangement, consumer attitude, if there were any actually, did not have to be considered, primarily because they were irrelevant to the business of running a hospital.

This period came to an end during the closing phases of World War II. The unprecedented increase in the number of patients that the hospitals had to serve, the increase in the number of services they had to provide, and the increased cost of all the services, combined simply to explode the old economics of hospital care. It was a period when practically all of the hospitals found themselves in serious financial difficulty. Socialized medicine became a serious threat.

It was discovered at that time that the hospitals were doing much better in those areas where successful Blue Cross plans had been established, and some hospitals found themselves impelled by the obvious facts to take a serious view of the financing of hospital care. The national attitude towards Blue Cross changed very rapidly. The building up of adequate consumer income for hospital care became important to the hospitals as a condition for survival. The consumer dollar has become a very important objective in hospital operations during the past ten years, the building up of general consumer income through pre-payment, a recognized hospital interest.

Otherwise, the hospitals have continued to operate in their traditional manner, making their decisions on the basis of dedicated institutional evaluations of their needs. The facts of consumer cost consciousness, while recognized, have perhaps been treated too often as a sort of nuisance that one had to live with.

The present situation is the result of the clash of these two forces, in my opinion—the force of the traditional hospital concept of dedicated progress-centered institutional management, and the force of consumer cost consciousness built up and aggravated through frequent hikes in prepayment costs.

Of course, the hospitals could not have made the phenomenal and remarkable progress they have made during the last 20 years, had they budgeted themselves according to what the consumer at any time thought was the most he could pay for hospital care. The consumer's notions of what the best hospital care in the world should cost certainly offer no objective criteria for hospital management.

It is not my theme that hospitals should have adopted at any time the policy of budgeted quality or budgeted progress. What I am trying to say is that where we may have failed was in establishing a community of real understanding between the hospitals and the consumers.

The Background

The present situation did not come as a surprise to most of us, I am sure. Prepayment spread rapidly. Before we knew it, about half of Michigan's population was covered by Blue Cross-Blue Shield. In our dealings with Blue Cross, we had to accept the fact that costs are a very important consideration. Slowly, and certainly not always without resistance, but very definitely, we became cost conscious in our operations. The uniformity of the payment we received began to impose an inescapable leveling of service. This was something

none of us liked, but we had to get used to it, and we did, and did pretty well under it.

The reimbursable cost formula introduced after World War II is another fact that imposed considerations of cost in the planning and management of our business. In contrast, the more the hospitals felt the pinch of this increasing emphasis on cost, the more demanding the customers became with their demands consistently way ahead of their willingness to pay.

We can say, with justice, I think, that we have done our best during these dynamic and confusing years to adjust ourselves to the realities of pre-payment. The phenomenal growth of voluntary pre-payment can be considered evidence of some weight that we in the hospitals have worked hard to make it a success. All this is true. All the things I have mentioned and many more can be offered in evidence of the sincere and consistent efforts that the hospitals have made to make voluntary pre-payment an adequate and economically satisfactory vehicle for financing hospital care.

We did all this, it is true, but there is a question, or a couple of them, that we should ask ourselves. Is there some reason for feeling that while we did all this, our deep inward impulse all the time was not to come face to face with the consumer, but to deal with him at arm's length, as it were, or second hand, through Blue Cross? Did we strive too much, perhaps to maintain an unwordly attitude toward the consumer dollar and consumer opinion? Has our attitude in its way been excessively pre-1912, when hospital and medical services were things we philanthropically provided for the patient, and were not things which he was prepared to pay for and fight for as the basic necessities of life, and as essentials for all of the hopes he has for his family's happiness and his own success?

This may be where we missed the boat. Prepayment works basically through the mechanism of group enrollment. When an employee group is enrolled, the hospitals acquire or organize cohesive groups of consumers among whom communication is simple and easy. Their common investment in pre-payment gives them a potential common economic consciousness about hospital costs, and this potential common consciousness can be changed into a strong group reaction in the event of a few rate raises, or a few impressive grievances. We are not selling carpeting or shrubbery. The services we deal with touch the deepest of human emotions.

Many of these consumer groups, these enrolled groups, are organized and belong to larger national groups of organized labor. We have created, through prepayment, a large monolithic community of consumers, bound by a common tie and capable of expressing their dissatisfactions either with the services or their cost with disturbing and effective force.

Politicians have come to recognize the advantages they can gain by exploiting the dissatisfaction of our consumers with the cost of our services. As a result, the government has made an ominous back-door appearance on the scene, raising a serious threat of government regulations of hospitals. These are facts, I believe, we should consider most carefully in trying to come to understand the possible errors of the past that may have brought us to this present situation. These facts about the new consumer-based economics of hospital care cannot be ignored, we are quite certain, if we are to appraise soberly what we are to expect in the future.

Two Schools of Thought

The present hospital view of the financing of hospital care is centered about the facts and consists for the present of two schools of thought. A certain number of hospitals have taken a standing against the present Blue Cross formula, which imposes limitations or ceilings on Blue Cross payments. Their objections cover four important points as I see them.

1. The Blue Cross action contradicts the accepted view that Blue Cross is the agency of the hospital.
2. Hospital costs are justified, and there is no reason why hospitals or Blue Cross should apologize for them.
3. The Blue Cross formula, in its present state, is unworkable, because it is complicated and therefore not susceptible to proper administration.
4. The Blue Cross action takes the responsibility for the control of the quality of hospital care out of the hands of the hospitals' governing boards, which are made up of true representatives of the community.

On the other hand, there are other hospitals in the state whose directors believe that the broad community acceptance of its programs, which Blue Cross has achieved, is one of the most important aspects of its success and the real strength

at the present time of the voluntary non-profit hospitals. Moreover, Blue Cross did not achieve its success unilaterally, but with and through the active support and cooperation of tens of thousands of citizens, including leaders in organized labor, management, farm organizations and other groups of citizens. The whole movement has been built up through community effort with consumer's money and consumer's confidence. Blue Cross has become the symbol of a way of hospital care that is today identified with the voluntary non-profit hospitals.

For these reasons, say these hospitals, it must be recognized that the consumers, above and beyond their enormous economic power have a moral right to be heard and considered. The consumers have their views about the justification of present hospital costs. They may be wrong, as I think they are, but even if they are wrong and completely wrong, they have a right to be heard, and they have a right—while the situation is confused, as it certainly is now—to have their day in court.

These latter hospitals believe that the Blue Cross formula is a sensible recognition of the needs for a self-imposed limitation to carry us through the present emergency. While Blue Cross is the agency of the hospitals, it is their agency in a community undertaking that constitutes, for all concerned, a great public trust, and its obligations to its members and the public in general should be faithfully honored by the hospitals as being, in effect, their obligation and their trust. These are, in my opinion, the two major hospital conditions in Michigan at the present time. Until the University of Michigan study, which I mentioned earlier, is completed, and we have the data for a broader appraisal of the whole problem, these two positions will undoubtedly be firmly maintained.

The Two Sides of the Coin

Looking ahead to what we may reasonably expect, it is a safe assumption, I believe, that when the present emergency has passed, the view of Michigan's hospitals on the financing of hospital care will be a workable compromise between the two positions. There are vital prerogatives which the hospital cannot sacrifice to the opinion of the market place without actually destroying the sources of its energy and unparalleled progress. But it will also have to be recognized, in the process of compromise ahead of us, that the consumer is not paying peanuts for his prepaid coverage, and that methods must be devised to bring greater stability to the financing of hospital care. The consumers have a grave responsibility with the hospitals in this try for stability.

In the hospital's view of the financing of hospital care, it is imperative, I am convinced, that we prepare ourselves for one inevitability. This is that a considerable degree of budgeting will be the lot of hospitals for some time to come. I believe it is imperative that we accept this inevitability in our working view of the financing of hospital care, because if we do, then we can begin to adjust ourselves at once to the habits and methods of working under these conditions.

The role of the hospital in the health of the community is greater than it ever was. Therefore, let us face the problems of this emergency realistically and concentrate our energies on the important business before us. This is how to negotiate successfully, under restricted economic conditions, the necessary improvements in the quality of our services, and maintain the tempo of progress that has distinguished our hospitals thus far in their career.

The Physician Views Financing of Hospital and Medical Care

By Max Lichter, M.D.
Detroit, Michigan

THE PROBLEMS in planning prepayment medical care programs faced by physicians are manifold and quite complex. I do not think that I know all of the problems, nor can I say I understand all of those of which I am aware. The problems would appear to fall into two main areas:

1. Those which arise out of an understanding of what needs to be done, with recognition that practical measures can be developed to achieve a solution.

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2. Those which arise out of a firm conviction that there are deeply rooted traditional relationships which are not readily amenable to change.

It would appear at first glance that there is a degree of incompatibility between these two major areas which I have mentioned. While the two views may seem irreconciliable, both can be united in a single area of understanding. You will find few physicians who disagree with the philosophy and even the necessity of pre-payment in medical care. There will be disagreement in the method of implementation, however.

It must be remembered that the practice of medicine, which can be regarded as an Art, is something which is personal and intimate. Because it is so very basic, the relationship that exists between a patient and his physician can never be minimized or dismissed as inconsequential. In the final analysis, the patient deals face to face and alone with his physician; and the physician deals with one patient at a time—singly. As you well know, this condition has legal and moral and ethical status. On the other hand, this transcendent relationship should not be used by some physicians as a major and overriding reason for not favoring or encouraging the development of methods to make medical care more available from a financial standpoint. Therefore, any planning must bear in mind the legitimate feelings of physicians in their sincere desire to keep the practice of medicine the personal Art which it is.

The practice of medicine being what it is, not solely a scientific and objective pursuit, is inherently inefficient when measured by economic standards. While patients' problems may fall into very broad categories, there are many niches within each category which defy precise measurement. A symptom does not always mean a specific illness or disease. Take for example a pain in the epigastrium. It could mean an ulcer, gastritis, gall stones, pancreatitis, retroperitoneal tumor, worry, anxiety, anger, or overindulgence. There is no single simple way to determine what is producing this simple symptom. Within the limitation of practicality no minimal set method of testing could pinpoint the cause, though it might indicate a possibility. But even if a simple set of testing procedures could be devised there is one ingredient that could not be mixed into the "batter," and that is a physician's judgment, which is achieved by his knowledge, experience and interest. Any medical care planning which negates this premise is adding to the problem rather than dealing with it.

Economics Cannot Be Overlooked

One might say that an ideal situation would be one in which the physician keeps himself completely detached from the financial side of medicine while he is rendering the highly-motivated service which only he can offer. While this viewpoint is idealistic there is certain weakness in the position. Generally speaking, all physicians are dedicated within their capabilities to their profession. However, it must be remembered that fundamentally physicians are human beings having the same ambitions and aspirations all people have, the same desires for status and position, and subject to the same impact of our ever changing socio-economic culture. The plain fact is that physicians want security, homes, families, the good things of life, all of which come from hard work and human striving. The degree to which they achieve these cannot be answered solely by outside forces.

What must result is that physicians should be left free to deal with the professional aspects of medicine. But there must be inherent in any planning a stabilization of the economic aspect of the practice of medicine. This can be done by physicians. Both of these major points will work in the interests of the patient and of his physician.

Prepayment for medical care is still relatively new. It is an approach which is still in its evolutionary development. By no means has there been a solution to this worthwhile project. Certainly the very rapid growth, as measured in terms of tremendously increasing enrollment in plans, thoroughly reflects the value the public places on medical services. Further indcated is the great interest on the part of the public in being able to meet the cost of medical care services when they are needed. We are still groping for answers, methods, and, most important, for understanding. If we keep this clearly in mind then problems can be faced in a cooperative effort to resolve them. This can only lead in a dynamic sense to an ever-improving program.

Each Is Important

In terms of a cooperative approach, it can be recognized that medicine, management, labor—all interested in the welfare of the consumer of medical care—each have their important role to play. Management, as a community force, contributes

greatly to the financing and purchase of medical care, and should therefore be conceded a legitimate interest in medical care planning. Labor should be recognized as a community force representing the consumer's interest and having a legitimate role in planning.

In the triad—administration, financial, professional—of medical care plan functioning, it should be accepted that management and labor have a proper role in administration and finance. However, they cannot intrude themselves into the professional side of medical care plan operation. This should, in a cooperative sense, be left exclusively to the medical profession. Certainly, the desires of the consumer should be carefully considered by physicians in this regard. It should be pointed out that what may be desired and what may be necessary are not always related and should be subjected to the test of what is practicable.

Only physicians have the necessary understanding of what really is the practice of medicine and what really constitutes the needs of patients in terms of medical care. I do not mean that physicians should be dogmatic in this position, but, after sincere cooperative discussion, the final decision in such matters should be left to them. This would require a considerable degree of interest upon the part of physicians in the matters of administration and financing the cost of medical care. I am sure you will agree that physicians are capable of such understanding and would, in an atmosphere of cooperative discussion, consider the judgment of those better qualified in these areas than themselves.

One of the major problems facing physicians in the financing of medical care is their fear that their freedom might be compromised. Some of this cannot be regarded as being unfounded. For example, there is strong advocacy for changing the method by which medical care will be furnished. The physician will not be recognized as an individual entrepreneur, but rather as a cog in an automated machine. Any planning which is disruptive in its character can only be achieved by disruptive means. This must be avoided in the interest of cooperative solution of problems.

The Question of "Quality"

Another factor in the physician's uneasiness is the seeming impugning of his ability to furnish good medical care. So much has been said about "the quality of medical care." This is something which is very difficult to understand, because we cannot perceive any precise method of measuring this in terms of any new system of financing medical care. We know that physicians always strive to keep abreast of the technologic advances in medicine and to improve their understanding of the problems of people. We of medicine, by our own volition, without any coercion by medical care plans, have developed methods of individually and collectively improving our abilities. I am sure that all of you are familiar with the Joint Accreditation Commission and the wonderful strides it has made since its inception a few years ago. As one contemplates its objectives and progress there need be no fear that the equality of medical care will not be a concern of the medical profession. This intangible "quality" is measured by the inward feeling of immense satisfaction that an individual physician experiences when he knows that he has done his job well. How does one measure the sense of satisfaction a patient has with his medical care? Isn't this an important factor to be considered in equating "quality"? Since it is so intangible a thing, "quality of medical care" will probably defy precise measurement.

There may be isolated instances where poor medical care is furnished by individuals. These are obvious to anyone. But they can be dealt with by physicians. You cannot indict an entire profession on the basis of transgression by a relative few. I would point out that we think no less of the worthiness of the labor movement, because of a mere handful of rascals in its ranks. Defectors in industry do not bring wide calumny on the heads of management because we hear of an occasional sinner.

A Look at the Record

Statistics can demonstrate the effect of improved medical techniques and practices on such things as infant and maternal mortality, morbidity and mortality rates, and on increased longevity. This was accomplished before the financing of medical care became so widespread and has continued through the infancy and even in the face of opposition to such planning. Such steady improvement will continue regardless of any impetus by, or the ultimate role of the pre-payment of medical care. It comes about only by the dedication and motivation of a profession.

Another thing in this connection that may confuse physicians is, if they are deficient in rendering

quality medical care now, how would a new method of furnishing medical care improve the situation since the same physicians, produced by the same medical educational system, taking care of the same patients, would be needed to furnish the medical care in a changed system. No, it isn't schemes for providing medical care that affect the quality of that care; it is physicians who, under any circumstances, affect the quality of medical care.

Another problem that concerns us is the seemingly overweening preoccupation with the cost of medical care. As a matter of fact, we should admit that this is really the major reason why the financing of medical care concerns all of us. This is a valid factor which deserves a lot of consideration. But when it is used as a major argument to criticize a profession and to imply that we are "out to get all we can" a natural sense of resentment arises. And the same feeling arises when cost furnishes the main reason for changing the way medical care is provided.

I would like to know just what is proper cost in financing medical care? To what do we relate cost? What is our bench mark? Or to put it another way, what is the point we must reach where cost is not a factor? When these questions are answered we then might understand what our critics are talking about.

We know that the total cost of medical care has been rising, but you are aware that physicians' fees have not increased proportionate to other services in our economy. It seems a bit paradoxical that prepaid medical care coverage was devised to enable people to avail themselves of more and more medical care; and yet when people do this which they have been encouraged to do, and physicians thereby are rendering more and more service to patients, we find ourselves charged with being responsible for the increase in these costs. We find it strange that in view of the enormous advances in medical technology which have been so great a boon to mankind we are charged with responsibility of increasing medical costs.

I would say that medicine can contribute much to the solution of problems if we can dispense with rationalizations. The least change in medical practice and the greatest amount of service to the public should be a major objective of planning. I am sure that medicine is willing to recognize the role of other interested groups provided these groups are willing to recognize the role of medicine. Cooperation and cooperative discussions will bear fruit if they are nurtured in an atmosphere of sincerity.

Leadership Has Arisen

Medicine can provide leadership of a reasonable character which will prove valuable in dealing with problems. There is ample evidence that once again this is occurring. Leadership arises, always, when it is needed. It must not be thought that "it is too late." Nothing is ever "too late" when its awakening is for the common good. This leadership can interpret to both the public and the profession the problems and solutions in the financing of medical care. The profession would maintain an awareness of the changes occurring in our economic climate, as an important part of it, but not as the cause requiring the changes. Within the frame work of its basic philosophy, medicine can adapt to the changes in our culture.

In Michigan we have resumed in the last two years our role of leadership. As you know, we have developed a "Statement of Principles" which state what we feel the people of Michigan are entitled to; the commitments we, as an organized group of doctors, will make in support of our Principles; the benefits we insist must be incorporated in any acceptable pre-payment plan. In our Principles we insist that all matters pertaining to the professional side of the practice of medicine must be left in the hands of physicians. We have a means prescribed for the review of the actions of our members in relation to the implementation of the program. We have provided a means by which the public, as well as insurance carriers, can come to the Michigan State Medical Society with any problems which may perturb them. We offer to any insurance carrier or plan which will abide by our Principles the endorsement of the Michigan State Medical Society.

We recognize that one of the most important responsibilities of the Michigan State Medical Society is that of communicating with its members. To that end in 1958 there was conducted a rather intensive professional relations program carried out by the PR staff of the Society. Prior to that a great number of meetings were held in each of the Councillor districts of our State and, in addition, many explanatory meetings with hospital medical staffs. In addition, quarterly reports of activities in this field are prepared and distributed to each member and alternate of the House of

Delegates, the legislative body of the Michigan State Medical Society. We realize that much more needs to be done on a continuing basis.

Medicine's Rightful Role

I can tell you that the members of our state society are more aware than ever before of prepaid medical care insurance. There has been a certain amount of opposition based chiefly on some of the factors I have enumerated. There may be other reasons, but they are a bit too abstract to discuss at this time. However, I feel that this opposition is good, because it keeps the subject before the eyes and ears of our members, and because it improves and deepens our thinking on this very important subject.

Medicine should not be placed in a position where it feels it must meet threats and therefore must be defensive. It must be assigned, and accept a leading role in coping with the problems involved in the development of acceptable means for financing medical care. Medicine should not be made to feel that it is a whipping boy for consumer representatives on one hand and the problems faced by hospitals on the other. Medicine should not be made to feel that it is being dictated to or negotiated with; it should be made to feel that it is a full and leading partner whose wise counsel should be sought. We should not be made to feel that the method by which professional services has been furnished over a great many years is no longer any good. Rather, means should be developed for continuing the private practice of medicine as a very worthy and personal thing.

I would say that we intend to maintain our Principles, recognizing them as an instrument capable of flexibility and therefore subject to change in the best interest of our patients and of physicians. We intend being temperate and interested in obtaining cooperation. I feel that our "Statement of Principles" represents a summation of our experience and understanding developed in the past twenty years. We have learned much but we recognize that there is much more to be learned. We feel that we have made important strides.

Blue Cross Views Financing of Hospital and Medical Care

By H. G. Pearce
Detroit, Michigan

THE PAST twenty-five years have established the fact that hospital and medical care are to be financed on a gradual payment basis rather than at the time of service. Prepayment and insurance growth are evidence of this fact. We have left behind the day when only the sick, at the time of their incapacity, were required to carry most of the cost of the medical system, including standby facilities and much of the teaching.

Our views on the financing of hospital and medical care must, therefore, take into account the continuance of a gradual payment method. In fact, we have every indication that the public wants this method to expand to include all hospital-medical services having financial impact greater than can be met out of current earnings at the time of service. The Blue Cross Plans with the broadest benefits have had the most rapid growth; the major medical form of insurance with its A to Z benefit range has had spectacular growth; and, the comprehensive, panel, and closed practice types of prepayment have expanded in number and subscribers.

But this picture of expansion has been clouded by a likewise growing public concern over the mounting cost of hospital and medical care. Each rate increase in Michigan has caused a greater number of people to seek narrower forms of coverage at lesser rates. The losses to date, following the most recent Michigan increase, are twice those of the comparable aftermath of the preceding increase in 1957. Major medical reached comprehensiveness only through compromise with costs by inflicting heavy deductibles and coinsurance to be borne by the patient at the time of care. These are the tangible evidences. The intangible evidences are far greater and more important.

They are the "handwriting on the wall." The

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sometimes farcical, sometimes tragic, and sometimes constructive insurance department hearings; in the legislative chambers; in the newspaper editorials; in the union halls; and, in the industrial budget conferences. All speak with one voice, "The cost of hospital care is high and still going up. Is all this cost necessary? Is all this money wisely spent? Can we get the hospital care we need for less money in some other way?" Why, why, why?

Facts Behind the Costs

Most of us here know the basic reasons for the increases in hospital costs:

1. Higher ratio of labor cost to product cost than exists in most of industry.
2. Updating of substandard wages and hours.
3. Expansion of costly facilities, services, and personnel due to rapid medical progress.
4. Added demands by a more enlightened public.
5. More care for more aged people.

We know these are the factors, but have we conditioned our buying public to ready acceptance of them? Have we elevated those costs to the priority position they deserve in the general economy? Have we found their *proper* position in the economy, and what are the factors which determine what priority the public will place on health costs and their payment? The answers to such questions are the key to our mutual salvation.

On St. Patrick's Day, 1939, a good County Cork Irishman, John F. Houlihan, Detroit Manager of The John Hancock Mutual Life Insurance Company, became the first of today's some 3,600,000 Michigan Blue Cross members. He paid $1.90 a month for his family group hospital plan.

Last month, March 1959, Mr. Houlihan paid $12.63 for his and his wife's Blue Cross protection. In round numbers, Mr. Houlihan is now prepaying six and one-half times as much for Blue Cross as he did in 1939—twenty short years ago. His hospital benefits have been broadened materially because the scope of services available in a modern hospital is much wider now than it was then. The fact is, nevertheless, that Mr. Houlihan, now retired, must pay at least six times as much for a good hospital care prepayment plan as he paid for the best plan available to him and his family more than twenty years ago. Most of the added cost is not the result of added benefits.

In a recent publication, Mr. T. Coleman Andrews, former U. S. Commissioner of Internal Revenue, tells us that inflation and taxes together have robbed our dollar of about two-thirds of its purchasing power in that exact same twenty-year span.

In the present economy, Mr. Houlihan needs three dollars to do the work of one 1939 dollar, but his hospital prepayment requires more than six dollars to do the work of one. Mr. Houlihan, because he is retired, not only finds his dollars weaker, but finds they are fewer at the time when his medical and hospital needs are greater. He represents the side of our market referred to as "individual." The balance we refer to as the group market, and its problems we find are much the same. Why are costs up? What can we do about them?

Some Basic Reasons

The character of the group market has changed drastically since World War II. There has developed a strong trend toward centralization of business and industry into fewer and larger companies. Presently, more than 60 per cent of the employed population work for organizations that employ in two or more states.

During the late forties, the purchase of hospital and medical benefits were recognized as a matter for bargaining between management and unions and became a regular and tangible fringe benefit. Now more than 65 per cent of our Michigan subscribers have some employer contribution toward the cost of coverage—most of them have one-half.

The purchasing authority has been narrowed from millions of individuals to thousands of employers and unions. This change has removed much of the flexibility of the former market because the cost of hospital care must be weighed and made a part of long range budgeting for most employers and unions. Even non-union employers and employees are affected by the pattern of benefits and prices accepted in the bargaining structure. While we have had an expanding economy and general inflation, the governing forces affecting the general economy have created some regularity, thus facilitating future planning and budgeting.

Against this pattern, the providers of service and their fiscal agencies have imposed unexpected costs with greater than usual unpredictability and with more inflation. The extra inflation, while not commonly understood, is probably the more

justifiable and more capable of being explained and appreciated. We have no real indication that hospital and medical care have priced themselves out of the general economy; although there is strong argument that, for many people, hospital costs have priced themselves beyond the priority they are willing to accept. This calls for reassessment by the providers and the buyers. Buyers need a greater appreciation of the vitality of hospital services and the providers must not overplay the vital nature of their services. Our economy has not eliminated misery, suffering, or poverty.

Long Range Planning

The greater problem very easily stands to be the unpredictability of the providers' cost pattern. Because the elements contributing to hospital inflation are different, their cost results will be different, but we must not add to this difference through lack of understanding of the buyers' economics or through lack of coordination and planning. Our economy will afford the best, but there are times when new facilities, services, and incomes can be expanded and times when they cannot. There are barometers that can indicate those phases.

The American economy is a dollar economy. In one way or another, our plans, our objectives and, in fact, our ideals must be molded in phase with this dollar economy. The forces affecting the economy are large and must be reckoned with by like forces, even in the health care field. The economy is patterned and subject to more central control than ever before. Elements living from the economy must phase into it or suffer hardship or exclusion. There is less room for individualism in this respect than in most other aspects.

Hospitals have need for a fiscal agency capable of dealing with these economic forces on their plane. One with sufficient scope to become an economic barometer to both the public and to the hospitals, by properly analyzing fiscal developments on each side and properly converting such information for the intelligent use of the other parties.

1. The system needs more *planning* in the replacement and construction of facilities. Heretofore, our main financial consideration has been the procurement of capital or credit before proceeding. The subsequent upkeep or use costs have later contributed to the cost repercussion. These matters can be projected to the buyers in a manner that will assure maintenance costs before construction begins or tell us this is not the time.

2. In addition to the above-mentioned projection, there are numerous other matters of a financial nature that require more *coordination* between buyers and all providers of health services. Buyers' benefit needs as well as cost considerations need to be evaluated and balanced against available hospital facilities and hospitals' cost requirements, and vice versa.

3. As has been pointed out, possibly the most outstanding financial problem has been the untimely *scheduling* of cost increases. There is greater need for sensitivity to the financial effects of recessions and prosperities as well as the lesser changes between. Cost increases passed on to the public must be strategically timed in relation to financial ups and downs. Planning must be such as to permit scheduling of costs up to three years in advance if we are to come into phase with most buyers' budget requirements. Major changes affecting cost probably should be scheduled as much as five to ten years in advance.

Must "Communicate"

4. There is need for much more *communication*, explaining the nature of hospital financing to buyers and the public. We must convince them that hospitals are well and efficiently run in the public interest. This entails the imparting of understanding of the unusual make-up of hospital costs as compared with industry in general. We must communicate facts about cost changes farther in advance to permit the market to be properly conditioned to the changes.

5. We have established, at least to my satisfaction, that most hospital income will come from fiscal agents who employ the *insuring* principle. The risk involved is great enough that it cannot be shouldered by one or two hospitals or one or two groups. The insuring agency must be large enough to carry such risk and large enough to sense general economic trends in behalf of hospitals and buyers. Such agencies must also be large enough to help absorb and schedule the impact of noticeable cost increases. Such insurers must accommodate the smallest and the largest buyer's needs in order to stablize hospitals' income and offset the threat of governmental intervention. In turn, the continued sale of voluntary hospital benefit programs is dependent on a more stable hospital cost

situation. Price has become almost the most important aspect of the product.

6. *Subsidy* has become a growing element in the hospitals' financial picture. While, in the main, cost resistance has come from persons who are reluctant to place a sufficiently high priority in the budgeting for hospital services, the percentage of persons who are unable to fit such costs into their budget is growing. More persons are on fixed income and more people become "medically indigent" as the cost of hospital care advances.

The danger of governmental intervention based on this problem is great. Because the impact of this problem does not fall evenly on each hospital or each group of people, the problem must be spread across the shoulders of those able to pay. This must be done by insuring agencies and involves more than insuring the risk. Actual subsidy of certain classes of risk are involved by loading the risks who are able to pay their way and a little more.

What Must Be Done

The spreading of subsidy costs is no easy job in the voluntary market. It requires the utmost in community mindedness and this spirit tends to slack off in times of spiraling costs. Everybody must sell this concept and nearly everybody must accept it. This is a "must" item in the voluntary field. It virtually outmodes experience rating by insurers.

Most hospitals and buyers need a large fiscal agent through which this obligation will be discharged. Charity and voluntary donation can no longer carry this load.

7. The financing of hospital care must be approached in large scale. It is big business with significant effect on the general economy. All of the foregoing aspects of the problem must be approached in *wide scope*. Particularly the matter of subsidy requires that the insurer have scope enough to recognize the problem and to spread it.

8. *Service* is an all-important aspect relating to the financing of hospital care. The buyer must feel he will receive good hospital service, particularly when he is asked to pay more. In the prepayment sense of service, the buyer wants assurance that what he is asked to pay will substantially cover his hospital costs. There can be no major gaps after benefits have been delivered. Service benefits become increasingly harder to sell as costs increase because the full impact must be reflected in the rate. This is better than having cost impact at the time service is used, but not always appreciated in advance.

More than a Buffer

Blue Cross has been a buffer between the buyer and the provider in much of its past experience. It should function more nearly as an intermediary between buyer and provider in the future. Blue Cross has been looked to for cost counsel by buyers, and to a degree has functioned in this capacity. This function needs development, which should follow as we are brought into more planning and scheduling of hospital expenditures and become more capable of forecasting for buyers.

Because of the economic throes of 1958, and to a degree in 1959, Blue Cross was catapulted into the area of hospital cost limitation through the expedient of a more limited payment formula. This was simply a matter of economic survival and, admittedly, not a fully developed program with all of the quality and incentive factors we would like. Every effort will be expended to accomplish this refinement.

Studies and research, such as are now being conducted by the University of Michigan and the Blue Cross Research and Development Committee, are necessary to the finding and justification of the hospital cost priority in the economy. Meanwhile, it is necessary to remain attuned to the requirements of the present economy and to establish the maximum public understanding and confidence with whatever tools are available to us.

Commercial Insurance Views Financing of Hospital and Medical Care

By Joseph F. Follman, Jr.
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IN DISCUSSING the views of insurance companies toward the financing of hospital and medical care and in considering the financial problems which are presented and the solutions which are given consideration, it would appear of value to sketch, first, the background for such a discussion and then to proceed into the areas of specific interest here.

There are several basic developments which underlie such a discussion.

One of these is the rapid and radical evolution which has been proceeding in the provision of medical care in recent years. Included here are the introduction and wide use of the many so-called "miracle drugs," the equally miraculous new surgical procedures now commonly employed, the increased availability of medical care facilities, the increased public acceptance and use of hospital and medical care facilities, and the revised concepts of care in and out of the hospital, including the increased employment of nursing home, out-patient, and home care facilities.

Another development lies in the changes which have been taking place in our socio-economic existence as a people. The past two decades have been identified with a generally high standard of living, an ever-increasing mobility in our population, a high degree of personal taxation, smaller dwelling units, and a high degree of installment purchasing and mortgage indebtedness. Our birth rate has been rising rapidly. Our mortality rate has been declining. The proportion of our population over age sixty-five has been increasing. This latter can only mean an increase in chronic or longer term illnesses with an increasing demand for medical care and the use of medical care facilities.

The effects of these developments on the use of our medical care facilities are demonstrable in many ways too numerous to mention here. But they are broadly indicated in a brief glance at the personal expenditures of the American people for medical care. The Social Security Administration estimates that in 1957 the American people spent privately 15.1 billion dollars for medical care and health insurance. Of this amount, 11 per cent was paid directly to hospitals, 17 per cent to doctors, 11 per cent to dentists, 26 per cent for medicines and appliances, and 6 per cent for other services and forms of care. On a per capita basis, this amount was $88 compared to $52 a decade earlier. In terms of disposable personal income, however, medical care represented 4.94 per cent in 1957, compared to 4.03 per cent in 1948, an increase of less than 1 per cent.

These brief data serve to illustrate the high degree of utilization of medical care facilities in the United States and the proportions of the monetary expenditures for these services. . . .

Concommitant with these developments has been a marked evolution in the manner in which medical care is being financed. Perhaps the most pronounced of the changes in this area has been the rapid growth of voluntary health insurance as a means by which people spread the economic risk inherent in accidents and illness. Today, 121 million Americans have some protection through voluntary health insurance against hospital costs, 109 million against surgical costs, 73 million against regular medical costs, and more than 16.5 million against the expense of prolonged catastrophic disability through Major Medical expense insurance. Nearly two-thirds of the employed civilian labor force has some protection against wage loss due to disability. Last year, voluntary health insurers paid more than 4.8 billion dollars in benefits, an increase of 14 per cent over 1957. More than half of this amount was paid by insurance companies.

Meanwhile, qualitative improvement of coverages has kept pace with quantitative expansion. Benefits are now far more adequate than formerly in amount and duration. Guaranteed renewable insurance has become much more generally available. Coverages are more realistically designed. Protection is rapidly being extended among such

Mr. Follman is Director of Information and Research, Health Insurance Association of America, New York, N. Y.

specific population groups as the aged, those living in rural areas, and those employed in small groups. In a recent study of health insurance, the authors have commented that the insurance companies have demonstrated a capacity for great flexibility and imaginative improvisation.

It is significant that voluntary health insurance in the United States is made available in many forms and by various types of insurers. These include insurance companies, service plans like Blue Cross and Blue Shield, group medical practice plans operating on a pre-payment basis, plans that are self-administered by employers or labor unions, community plans, fraternal societies, and rural and consumer health co-operatives. Coverage is provided on an individual, family, association, or group basis. Each type of insurer has its distinctive approach, providing the buyer of insurance the opportunity to choose the kind of plan and coverage best suited to his needs and ability to pay. While the resulting heterogeneity can at times appear confusing and can present impediments to a ready simplified understanding of the subject, it is necessary to recognize that many of the aspects and concepts of voluntary health insurance must still be looked upon as experimental and that this form of insurance, like medical care itself, must remain in a state of evolution.

How, then, might this background be summarized? Perhaps Heraclitus provided the most apt summary for us centuries ago when he said, "Everything is flux." If there is any thought which should be held paramount in any consideration of the financing of hospital and medical care today, it is probably this aphorism from the classical world of the ancients.

Views of Insurance Companies

Against this brief background, what might be considered the views of the insurance companies? While it is impossible to represent the opinion of all insurance companies, the following might be considered some of the basic views currently and generally held.

1. *Validity of the Private Voluntary Approach.*—Insurance companies today are convinced of the validity of the private voluntary approach as basic to insuring against the serious costs of medical care. They have faith in the ability of voluntary mechanisms to adequately answer the challenge with which they are presented. As insurers they are striving with determination toward this end. They do not believe that it is the most efficient use of the insurance dollar to spend it for coverage against medical costs which are not serious to the individual or which can be anticipated and hence budgeted against. They, therefore, do not believe it in the public interest to provide insurance against the total of all forms of medical care costs. They are convinced that a given number of available dollars, be they those of an individual, an employer, a union, or a government, can be used to best advantage by providing protection against the more sudden and sizable medical care costs as contracted with either incidental or total costs.

2. *Care for the Indigent and Needy.*—With respect to that segment unable to finance the cost of health care for themselves, because of their limited or non-existent means, insurance companies take the view that such persons should have assurance that health care is available to them when they need it. To that end, insurance companies support the concept of public assistance programs to supplement the effects of voluntary agencies. As a service to the community, the insurance companies stand ready to make their knowledge and facilities available to assist in the administration of such programs. The public Funds available for medical care for the indigent and needy should at all times be sufficient to guarantee medically adequate care. If this were so, much of the present difficulty in financing hospital and medical care would be eliminated and hospital deficits would be greatly relieved.

3. *Equality of Payment.*—The majority of hospitals providing acute illness facilities are voluntary non-profit institutions depending upon patient income as their principal source of operating revenue, while otherwise depending on public support through voluntary contributions. Except for the public support and voluntary contributions, the rates which they would have to charge patients would be higher than those they now charge. This income category embraces not only cash paying patients, but also those patients who have their care financed directly or indirectly by third parties. The hospital's operating income, therefore, is largely determined by the hospital's pricing policies and the relationship between hospital cost and charges. It is recognized that pricing policies are properly the prerogative of the individual hospital in de-

termining the relationship between cost and charges for special accommodations. However, the hospital as an institution exists to provide service to the public as a whole with the level of charges for such services generally determined by the type or accommodation used. Since the hospital is a nonprofit institution, the overall charging policy should ideally operate to produce sufficient revenue to offset the operating cost during a fiscal period. However, in practice there is often a substantial differential between established charges to individual patients, and the amounts paid by large-scale contractors who, under certain conditions, guarantee payment for all their clients for the same accommodations. This practice, in the opinion of insurance companies, is inequitable to the public since it supports a discriminatory pricing policy which may either ultimately place the hospital in an unstable financial position or financially penalize the patient who pays for his hospital care at the higher level of reimbursement. It is the view of insurance companies that hospitals are entitled to be reimbursed at the same rates by all patients who pay for their own care, whether they pay themselves or through any form of prepayment or health insurance protection, and that it is in the public interest that the hospital charges be based upon sound cost accounting principles and that the charging policies developed by individual hospitals apply uniformly to all patients varying solely by the type of accommodation used.

4. *Free Competition Among Insurers.*—Previous reference has been made to the heterogenity of the institution of voluntary health insurance and why this is so. Insurance companies are convinced of the wisdom of this. They are convinced that monopoly has no place, nor should it have a place, in an area of such vital public and personal concern as modern medical care. Monopoly, whether public or private, tends to become irresponsive to changing needs and demands, to form a fixed pattern, and to become complacent. The keen competition which exists among insurers of all types in this country has spurred experimentation to devise new and better benefits and approaches.

5. *Freedom of Choice.*—Insurance companies are fiduciary institutions. They are not incorporated by the legislatures of the several states to provide services. Hence, they do not fight fires, bury the dead, care for widows and orphans, fight off bank robbers, repair damaged property, nor care for the sick or the hurt. The contracts they make with their insured provide for the payment of certain sums of money under stipulated conditions in the event of the occurrence of the loss insured against. Corollary concerns extend in one direction to the prevention of the loss insured against and in the other to salvage or rehabilitation after the loss has occurred. Hence, in the area of health insurance, monies are paid under three basic circumstances: (1) death and dismemberment as a result of accident, (2) loss of income as a result of sickness or accident, and (3) the occurrence of medical care costs resulting from sickness or accident.

This being the case, it is self-apparent that, within the confines of the insurance contract, health insurance as written by insurance companies permits complete freedom of choice on the part of the covered persons as respects the provision of their medical care. It, furthermore, provides non-interference with the doctor-patient relationship. It is the view of insurance companies that it is for the insured-patient, in consultation with his physician, to determine the form of care or treatment necessary under the circumstances. By this approach, maximum flexibility in the provision of medical care in relation to medical need is made possible. Today, it is not infrequent in certain circles to hear the charge made that the primary criticism of voluntary health insurance is that it exerts no control over the quality of the care provided. It usually is not clear whether "voluntary health insurance" is extended to include insurance company coverages or whether it is actually directed to plans comprised of or organized by the providers of care. More important, however, is the lack of preciseness of the words "control over the quality of care." As has been stated, it is the virtue of the approach inherent in the insurance company concept that there is no interference in the provision of care. Naturally, there are controls, the purpose of which is to define what is intended by the terms of the contract and to deter misuse of this intent. But the concept of insurance companies is that essentially any determination of the quality of care must rest with those professionally competent by training, tradition, and experience to arrive at such determinations—and with the patient.

Today, we read and hear a great deal on the subject of rising medical costs. On March 16, the cover of *U. S. News and World Report* featured

one of the principal articles of that issue under caption, "The High Cost of Being Sick." The *New York Times* recently headlined a reporting, "More Rises Seen in Hospital Cost." The Federal Reserve Bank of Philadelphia last December published a booklet, "Health Insurance Isn't Free." On June 2, 1958, the *New York Times* ran a comprehensive reporting under the caption, "Hospital Deficits Rise with Medical Gains." Twenty days later, the Shreveport, Louisiana, *Times* featured an article, "Health Insurance May Outprice Itself." These are simply examples.

Facts Behind the Headlines

Some of the basic facts behind these headlines are the following. In dollars, according to the U. S. Department of Health, Education and Welfare, the personal consumption expenditure for medical care in the United States rose from 7.4 billion dollars in 1948 to 14.4 billion dollars in 1957. According to the U. S. Department of Labor, the consumer price index (based on 1947-1949 prices) for medical care rose from 94.4 in 1947 to 138.0 in 1957, while the index for all items rose from 95.5 to 120.2. The American Hospital Association reports that the average cost per patient day in short-term general hospitals rose from $11.09 in 1947 to $26.02 in 1958. Health Information Foundation reports that medical care costs have increased six per cent a year between 1929 and 1957.

At first blush, and standing alone, these data appear frightening. They must, however, be qualified and evaluated. As the report by Health Information Foundation recognizes, on a per capita basis the increase in medical care costs has been from $24 to $89 between 1929 and 1957. However, the "real" increase (based on 1947-1949 prices) was from $32.86 to $64.78. In this same period, disposable personal income rose from $685 per capita to $1,812. Hence, as the report recognizes, while medical costs on an adjusted basis doubled, disposable personal income tripled.

There also is often a tendency to overlook the many entirely understandable reasons which lie behind the actual rise in medical care costs. In the field of hospital care, wages for hospital workers have, of necessity, been adjusted to a more adequate level and working hours have been brought more in line with the work day of other workers. All the costs of hospital operation, including food and equipment, have naturally felt the impact of the rise in living costs generally. The modern hospital requires much more expensive equipment than was formerly so. And there is today a greatly increased use of private and semi-private accommodations. With respect to physicians and dentists, they, too, have felt the impact of rising living costs and of the cost of equipment. Modern practice requires much more physical equipment and often more specialized para-medical personnel. The increasing specialization by physicians also has its understandable effect on costs. Drugs, too, have increased in diversification and the "miracle" drugs of today, and the research which lies behind them, are expensive to produce.

In addition to these basics, there has been more public demand for medical care and treatment than was formerly the case. This may be accounted for in many ways. Increased and warranted public confidence unquestionably plays a role. So does the constantly rising standard of living. So, also, do the changes in our ways of living so that care in the home is at times impossible and at other times undesirable. Increased health consciousness must be a further and important contributing factor. Important factors, too, are the increase in car population, our high maternity rate in recent years, the very high incidence of births taking place in hospitals under expert supervision today, the increasing number and proportion of aged people in our population, and the increasing incidence of chronic illness.

A final factor in increased medical costs is the presence of voluntary health insurance. This can operate in several ways. In the first place, the net cost of the insurance is often recorded as part of "medical costs" in computing the personal expenditures for medical care. Secondly, the presence of insurance can encourage the bringing about of needed medical care. Thirdly, insurance can have an inflationary influence on medical costs. One obvious way in which this has happened is in the reduction in the amount of hospital ward care and the increase in private and semi-private care.

There is some speculation, however, as to whether, barring general cost of living increases, the rise in medical costs will not tend to level off. Some argument can be made for this hypothesis in that many of the factors which have contributed to the rise in the past decade have now produced their major impact and should tend to follow the general cost of living index in the future.

However, a consequence of the increases in med-

ical care costs of necessary importance requires that insurance companies and other insurers seek higher premiums from their policyholders. This, in turn, causes questions to be raised by employers who pay so much of the cost of health insurance benefits, by labor unions through whose efforts so many of these plans are negotiated, and by others. Suggestions are made that steps be taken to control plan operations in one way or another to prevent the costs from rising or otherwise to eliminate the payment of unnecessary or excessive claims. The inference is sometimes drawn that if such measures to control costs are properly taken, costs can be established. The situation is by no means so simple. Among other things, the complex of factors entering into the rise in the costs of medical costs are not too ready measurable.

Obviously, there are areas where measures to control costs must be considered. Among these is the inefficient use of facilities. This includes poor scheduling of hospital admissions so that beds remain idle unnecessarily long. It includes the duplication of equipment that may be readily available elsewhere on a sharing or co-operative basis. Such situations call for constructive planning for efficient operation of the health professions. Progress can be made by careful examination of hospital admission practices in order to discern the degree of very short stay cases which may not have been medically necessary and to discern the degree to which hospital stays might be longer than necessary. Much more information in this area of consideration is needed. The study under way in Massachusetts by Health Information Foundation, and other similarly intended studies, should prove extremely helpful in evaluating this facet of medical care costs.

Some developments which should prove helpful are the many explorations in the use of ambulatory hospital care, nursing pools in hospitals, the joint purchase of drugs and supplies by hospitals, greater use of hospital out-patient facilities, a wiser use of nursing homes, and of the various forms of home care including visiting nurses, practical nurses, homemakers, and the all-inclusive organized home care programs. With greater availability of such facilities, and their general acceptance by physicians and the public, the costs of medical care might alter appreciably. From an insurance standpoint this would probably not result in reduced costs, but rather, it could mean a more efficient use of the premium dollar, particularly for the longer and more costly disabilities. There is wisdom in the words of Dr. James Dixon, when he says, "It is doubtful if any program for the assurance of hospital services for older people can be ultimately successful without taking into consideration the fact that care in nursing homes and similar type institutions must at the same time be equally available to the older person." When the several methods employed by insurance companies today in rapidly extending coverage to older people are considered, the importance of what Dr. Dixon has said becomes apparent.

The Question of "Abuse"

Another area for exploration includes the excessive provision of services because insurance is available to pay for them, or the practice of charging more for a given service simply because insurance is present. In many instances, these may be explained by the lack of understanding of the nature of health insurance on the part of some members of the medical profession, or their failure to realize their obligation to co-operate in making it work effectively in the interests of the public as well as themselves. Insurance company claim departments are on the lookout for these situations and deal with them depending on the individual circumstances.

The medical professions are increasingly aware of these problems and are devoting more and more time to them. Doctors' review committees are available in practically all areas to help adjudicate particular situations that are referred to them. In a number of instances, local medical societies are leading the way to a complete elimination of grounds for criticism of doctors' fees by adopting a dollar and cents conversion factor applicable to relative value schedules. The American Medical Association has recently urged all physicians to accept a level of compensation for medical services rendered the aged with low family incomes which will permit the development of insurance and prepayment plans at a reduced premium rate.

The insurance companies have long since been aware that the success or failure of voluntary health insurance will, in the end, depend so much upon the sympathetic consideration of the medical professions. In 1946, they formed the Health Insurance Council to seek the co-operation of the providers of care. A great deal has been accomplished and recently state and local committees

have been established to reach hospitals and doctors at the grass roots.

Insurance companies are also aware that it is their responsibility to design their coverages in such manner that unnecessary use of more expensive medical care than is necessary will be avoided and that the most efficient use might result from a given insurance premium dollar. The effort must constantly be to make plan operations as effective as possible. Dr. Frank C. Vogt, writing last month in the journal, *Group Practice,* has summed up the subject thus:

> "The major medical plans (of the insurance companies) which have appeared in recent years go far toward a workable solution to this many-faceted problem. By covering major illness only, and avoiding any attempt to insure against the minor, day to day medical expenses which can be borne much more economically by the patient than by insurance, a return has been made to employing insurance in its most efficient area. . . . No restriction is placed on where the service is rendered; it may be in the doctor's office or in a hospital."

An Ever-Changing Challenge

One of the most intriguing and challenging of the problems which face American society today is that of the provision and the financing of hospital and medical care. The development of this problem has resulted from many simultaneous and inter-acting stimuli; the tremendous advancement in the provision of medical care; the growth and increased availability of medical care facilities; the increased public demand for medical care as a result of a great many factors; an increasingly high rate of income taxation; a high degree of mortgaged indebtedness; vast socio-economic changes in our society; and the development and rapid growth of voluntary health insurance. Cognizance of this problem is largely the result of the active interest of a great many segments of our society, including the providers of care, organized labor, employers, our universities, foundations, government, and insurers. A multitude of studies and opinions on various facets of the subject are now existent. The result of these, however, while serving importantly to propel developments and progress, and to stimulate further thinking, often has been a confusion of opinions and counter-opinions, of charges and counter-charges, of diverse conclusions and evaluations drawn inevitably and of necessity from partial and incomplete information. Differing points of view are strongly, sometimes stubbornly adhered to. Emotions often run high. Partisanship and loyalties to viewpoints or approaches are staunch and vigorous. In fact, the only thing which at times appears to be absent from the panorama is objective discussion.

To say this is not to assume a cynical view. Actually, the subject is one which is rife with vitality and excitement. A great deal has been learned about it in the last decade. Unforeseen progress has been made and more will be made. The fact that discourses on medical economics inevitably take on distinctly dogmatic characteristics should not, perhaps, be surprising when one considers, as Igor Stravinsky has pointed out in his Harvard University lectures a decade ago, that every formal process proceeds from a principle and the study of this principle requires what is called dogma. The need we feel to bring order out of chaos, which need becomes so apparent to anyone approaching the field of medical economics, this need to extricate a straight line of operation from the tangle of possibilities, coupled with the indecision of vague thoughts, presupposes the necessity of some form of dogmatism.

Meanwhile, in any consideration of the subject it is important above all else to bear in mind that both medical care and the methods by which it is financed have been and will be engaged in a rapid and complex evolutionary process to such an extent that data, methods, and conclusions rapidly become outmoded; that information is always, of necessity, complete, lagging behind the progress which goes surging ahead; and that evaluations are not only inconclusive but extremely temporal. The fact is that, while we are gradually finding our way, the field of endeavor often called medical economics is still infinitely much more an art than a matter of scientific disciplines. This, then, argues that emotional reactions must be tempered, that patience must be employed despite a marked straining toward impatience, that objectively purposed knowledge must be diligently sought, and that, above all, the arbitrary freezing of a pattern, by whatever means, which would cut short much of the progress that is clearly before us should be avoided like the plague. The admonition of Boris Pasternak, in his controversial "Doctor Zhivago," that what has for centuries raised man above the beast is not the cudgel but an inward music, the irresistible power of unarmed truth, might well be heeded.

Michigan Medical Service

Payments for Services to Subscribers By Residence of Doctors Rendering Service

from March 1, 1940 through December 31, 1958

1.	Wayne	$132,549,070.48	41.58%
2.	Genesee	20,614,311.62	6.47
3.	Oakland	18,069,453.74	5.68
4.	Kent	12,471,828.82	3.91
5.	Washtenaw	11,688,028.29	3.67
6.	Ingham	10,661,825.16	3.34
7.	Saginaw	9,693,064.26	3.04
8.	Macomb	5,043,383.87	1.58
9.	Bay	4,765,968.80	1.50
10.	Kalamazoo	3,756,094.47	1.18
11.	St. Clair	3,604,027.87	1.13
12.	Calhoun	3,046,668.66	.96
13.	Muskegon	2,243,307.87	.70
14.	Berrien	2,068,504.28	.65
15.	Shiawassee	1,994,717.00	.63
16.	Grand Traverse	1,964,846.77	.62
17.	Jackson	1,863,229.03	.58
18.	Chippewa	1,787,741.38	.56
19.	Emmett	1,537,148.32	.48
20.	Ottawa	1,427,609.77	.45
21.	Alpena	1,415,734.42	.44
22.	Marquette	1,268,783.99	.40
23.	Van Buren	1,184,205.00	.37
24.	Lenawee	1,173,512.65	.37
25.	Clinton	1,104,334.00	.35
26.	Monroe	1,083,758.85	.34
27.	Isabella	1,074,431.65	.34
28.	Ionia	959,325.03	.30
29.	Branch	854,685.85	.27
30.	Lapeer	830,098.20	.26
31.	Wexford	820,669.50	.26
32.	Tuscola	809,729.15	.25
33.	Hillsdale	784,611.27	.25
34.	Huron	771,200.85	.24
35.	Houghton	743,818.49	.23
36.	Montcalm	722,824.50	.23
37.	Eaton	712,628.67	.22
38.	Allegan	664,546.00	.21
39.	Gratiot	640,459.50	.20
40.	Delta	606,992.75	.19
41.	Cheboygan	557,547.20	.17
42.	Livingston	543,649.75	.17
43.	St. Joseph	534,055.65	.17
44.	Dickinson	485,751.85	.15
45.	Sanilac	463,491.25	.15
46.	Ogemaw	430,365.70	.14
47.	Oceana	411,937.75	.13
48.	Mason	375,306.40	.12
49.	Osceola	369,020.54	.12
50.	Presque Isle	367,108.75	.12
51.	Mecosta	365,406.50	.11
52.	Charlevoix	355,955.22	.11
53.	Gogebic	295,676.29	.09
54.	Menominee	294,600.85	.09
55.	Iosco	290,131.86	.09
56.	Barry	269,704.90	.08
57.	Ontonagon	260,249.25	.08
58.	Newago	245,697.35	.08
59.	Schoolcraft	243,043.50	.08
60.	Manistee	242,079.45	.08
61.	Crawford	238,925.75	.07
62.	Otsego	223,493.54	.07
63.	Baraga	221,478.50	.07
64.	Luce	203,526.55	.06
65.	Missaukee	200,869.00	.06
66.	Gladwin	175,612.99	.06
67.	Midland	173,998.90	.05
68.	Arenac	167,125.90	.05
69.	Leelanau	163,080.50	.05
70.	Benzie	144,302.18	.05
71.	Cass	133,663.50	.04
72.	Iron	99,184.25	.03
73.	Clare	72,064.25	.02
74.	Alcona	68,936.00	.02
75.	Antrim	55,950.00	.02
76.	Alger	48,925.25	.02
77.	Mackinaw	44,970.25	.01
78.	Roscommon	35,489.25	.01
79.	Kalkaska	20,992.50	.01
80.	Montmorency	16,133.00	.01
81.	Lake	8,866.50	.01
82.	Keweenaw	3,033.00	
83.	Oscoda	1,894.00	
	Total	$279,000,476.35	87.53%
	Total Michigan M.D.'s	$279,000,476.35	87.53%
	Out-of-State Doctors and Unclassified	7,348,627.27	2.31
	Paid to Osteopaths	32,400,027.63	10.16
		$318,749,131.25	100.00%

Michigan State Medical Society

The Ninety-fourth Annual Session

D. Bruce Wiley, M.D.
Utica
Council Chairman

G. B. Saltonstall, M.D.
Charlevoix
President

K. H. Johnson, M.D.
Lansing
Speaker

L. Fernald Foster, M. D.
Secretary

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan, September 27-28-29-30-October 1-2, 1959. The provisions of the Constitution and Bylaws and the Official Program will govern the deliberations.

G. B. Saltonstall, M.D.
President

D. Bruce Wiley, M.D.
Council Chairman

K. H. Johnson, M.D.
Speaker

J. J. Lightbody, M.D.
Vice Speaker

Attest:

*L. Fernald Foster, M.D.
Secretary

*Deceased.

J. J. Lightbody, M.D.
Detroit
Vice Speaker

THREE-DAY SESSION OF HOUSE OF DELEGATES

September 27-28-29, 1959

First Meeting—Sunday, 8:00 p.m.

The 1959 House of Delegates of the Michigan State Medical Society will hold a three-day session beginning Sunday, September 27, at 8:00 p.m. The business of the House of Delegates will be transacted in the Ballroom of the Pantlind Hotel, Grand Rapids.

The House will meet also on Monday, September 28 at 9:00 a.m. and 8:00 p.m., and on Tuesday, September 29, at 9:00 a.m. and at 8:00 p.m.

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

SEATING OF DELEGATES

"Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate next on the list as certified by the Secretary of the component County Society involved." —MSMS Bylaws, Chapter 9, Section 6.

Michigan State Medical Society

The Ninety-fourth Annual Session

PANTLIND HOTEL—CIVIC AUDITORIUM, GRAND RAPIDS

SEPTEMBER 27-28-29-30; OCTOBER 1-2

INFORMATION

- **GRAND RAPIDS WILL BE HOST TO MSMS IN SEPTEMBER, 1959.**

- **MSMS HOUSE OF DELEGATES** convenes Sunday, September 27, at 8:00 p.m., Ballroom, Pantlind Hotel. It will also hold two meetings on Monday, September 28 and two on Tuesday, September 29.

- **THE PROGRAM OF THE ASSEMBLY** for the 94th Annual Session of the Michigan State Medical Society lists guest speakers from all parts of the United States and Canada. They are the usual stars in the medical world who always grace the podium at annual conventions of the Michign State Medical Society; they insure a valuable concentrated refresher course in all phases of medicine and surgery for the busy practitioners of Michigan, neighboring states and the Province of Ontario.

- **DATES OF SCIENTIFIC ASSEMBLY:** Tuesday noon through Friday noon, September 29-30, October 1-2, 1959.

- **REGISTRATION**, Tuesday 10:00 a.m. (September 29) through Friday noon (October 2), Civic Auditorium. Present your State Medical Society, American Medical, or Canadian Medical Association membership card to expedite registration.

- **NO REGISTRATION FEE FOR STATE MEDICAL SOCIETY AND CMA MEMBERS.**
  Doctors of Medicine, who are not members of their state medical society or the Canadian Medical Association, will be accorded the privileges of the MSMS Annual Session upon payment of a $25.00 registration fee.

- **DINNER-DANCE, WEDNESDAY, SEPTEMBER 30, 1959**

  The Officers Night Dinner Dance, to which all MSMS members and their ladies are cordially invited, will be held in the Pantlind Hotel, Grand Rapids, Wednesday evening. Reception at 7:00 p.m.; dinner, 8:00 p.m. Sponsored by the Michigan State Medical Society and its Woman's Auxiliary.

- **REGISTER AS SOON AS YOU ARRIVE. ADMISSION BY BADGE ONLY.**

- **MEMBERS OF MICHIGAN MEDICAL SERVICE** will meet in annual session, Tuesday, September 29, at 2:00 p.m. This meeting will follow the annual MMS luncheon which will be held in the Ballroom of the Pantlind Hotel.

- **ALL SUBJECTS** at the MSMS Annual Session are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

- **POSTGRADUATE CREDITS** given to every MSMS member who attends MSMS Annual Session.

- **SIX ASSEMBLIES**—16 Section Meetings—all on September 29-30-October 1-2.

- **SECTION MEETINGS** will follow the daily Assemblies, Tuesday, Wednesday, Thursday, Friday.

- **PAPERS WILL BEGIN AND END ON TIME.** The MSMS scientific meeting always features by-the-clock promptness and regularity.

- **TECHNICAL EXHIBITS** will contain much of interest and value. Two daily intermissions to view the exhibits have been arranged.

- **JAMES W. LOGIE, M.D., GRAND RAPIDS,** is Chairman of the Committee on Arrangements for the 1959 Annual Session.

- **CABARET-STYLE DANCE AND ENTERTAINMENT,** with the compliments of the Michigan State Medical Society, will be held in the Ballroom of the Pantlind Hotel on Thursday evening, October 1. All who register and their ladies are cordially invited to attend.

SCIENTIFIC ASSEMBLY

Tuesday-Wednesday-Thursday-Friday

September 29-30-October 1-2, 1959

SAVE AN ORDER FOR THE EXHIBITORS AT THE MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

Michigan State Medical Society

Ninety-fourth Annual Session

HOUSE OF DELEGATES

PANTLIND HOTEL, GRAND RAPIDS, SEPTEMBER 27-28-29, 1959

ORDER OF BUSINESS*

SUNDAY, SEPTEMBER 27, 1959

Ballroom, Pantlind Hotel, Grand Rapids

6:00 p.m.—Registration

8:00 p.m.—First Meeting

1. **Call to Order by Speaker**
2. **Report of Committee on Credentials**
3. **Roll Call**
4. **Appointment of Reference Committees**
   - (a) On Officers' Reports
   - (b) On Reports of The Council
   - (c) On Reports of Standing Committees
   - (d) On Reports of Special Committees
   - (e) On Constitution and Bylaws
   - (f) On Resolutions
   - (g) On Special Memberships
   - (h) On Rules and Order of Business
   - (i) On Legislation and Public Relations
   - (j) On Hygiene and Public Health
   - (k) On Medical Service and Prepayment Insurance
   - (l) On Miscellaneous Business
   - (m) On Executive Session
   - (n) On National Defense and Disaster Planning
5. **Speaker's Remarks—K. H. Johnson, M.D., Lansing**
6. **President's Remarks—G. B. Saltonstall, M.D., Charlevoix**
7. **President-Elect's Remarks—M. A. Darling, M.D., Detroit**
8. **Annual and Supplemental Reports of The Council —D. Bruce Wiley, M.D., Chairman of The Council**
9. **Report of Delegates to American Medical Association—W. A. Hyland, M.D., Grand Rapids, Chairman**
10. **Brief of Annual Report of Woman's Auxiliary—Mrs. Robert E. Reagan, Benton Harbor**
11. **Brief of Annual Report of Michigan State Medical Assistants Society—Miss Donna Hislop, Muskegon**
12. **Report on Michigan Medical Service**

*See the Constitution, Articles IV, VII and XII, and the Bylaws, Chapter 9 on "House of Delegates."

MONDAY, SEPTEMBER 28, 1959

Ballroom, Pantlind Hotel, Grand Rapids

9:00 a.m.—Second meeting

13. **Supplemental Report of Committee on Credentials**
14. **Roll Call**
15. **Awards:**
    - (a) Selection of Michigan's Foremost Family Physician
    - (b) Fifty-year Awards
16. **Resolutions†**
17. **Reports of Committees of the House of Delegates**
    - (A) Permanent Advisory Committee on Fees
    - (B) Committee on Committees
    - (C) Study Committee on Term of Councilor
    - (D) Ad Hoc Study Committee on Regional Election of members of Michigan Medical Service
18. **Reports of**
    1. **MSMS Standing Committees**
       - (A) Committee on Postgraduate Medical Education
       - (B) Preventive Medicine Committee
         - (1) Committee on Rheumatic Fever Control
         - (2) Cancer Control Committee
         - (3) Maternal Health Committee (and Subcommittees)
         - (4) Venereal Disease Control Committee
         - (5) Tuberculosis Control Committee
         - (6) Occupational Medicine Committee
         - (7) Mental Health Committee
         - (8) Child Welfare Committee (and Subcommittees)
         - (9) Iodized Salt Committee
         - (10) Geriatrics Committee
         - (11) Committee on Diabetes
       - (C) Public Relations Committee (and Subcommittees)
       - (D) Ethics Committee
       - (E) Legislative Committee
    2. **MSMS Special Committees**
       - (A) Scientific Radio Committee
       - (B) Advisory Committee to Woman's Auxiliary
       - (C) Advisory Committee to Michigan State Medical Assistants Society
       - (D) Mediation Committee
       - (E) Study on Prevention of Highway Accidents Committee

       Reports of the Committees of The Council, including Committee on Scientific Work, are included in Annual Report of The Council

†All resolutions, special reports, and new business shall be presented in writing in triplicate (Bylaws, Chapter 9, Section 10-m).

MONDAY, SEPTEMBER 28, 1959

Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m.—Third Meeting

19. **Supplementary Report of Committee on Credentials**
20. **Roll Call**
21. **Unfinished Business**
22. **New Business**
23. **Reports of Reference Committees**
    (a) On Officers' Reports
    (b) On Reports of The Council
    (c) On Reports of Standing Committees
    (d) On Reports of Special Committees
    (e) On Constitution and Bylaws
    (f) On Resolutions
    (g) On Special Memberships
    (h) On Rules and Order of Business
    (i) On Legislation and Public Relations
    (j) On Hygiene and Public Health
    (k) On Medical Service and Prepayment Insurance
    (l) On Miscellaneous Business
    (m) On Executive Session
    (n) On National Defense and Disaster Planning

TUESDAY, SEPTEMBER 29, 1959

Ballroom, Pantlind Hotel, Grand Rapids

9:00 a.m.—Fourth meeting

24. **Supplementary Report of Committee on Credentials**
25. **Roll Call**
26. **Unfinished Business**
27. **New Business**
28. **Supplementary Reports of Reference Committees**

TUESDAY, SEPTEMBER 29, 1959

Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m.—Fifth meeting

29. **Supplementary Report of Committee on Credentials**
30. **Roll Call**
31. **Unfinished Business**
32. **Supplemental Report of The Council**
33. **Supplementary Reports of Reference Committees**
34. **Elections**
    (a) Councilors:
        13th District—T. P. Wickliffe, M.D., Calumet—Incumbent
        14th District—B. M. Harris, M.D., Ypsilanti—Incumbent
        18th District—Wm. Bromme, M.D., Detroit—Incumbent
    (b) Delegates to American Medical Association
        J. S. DeTar, M.D., Milan—Incumbent
        W. A. Hyland, M.D., Grand Rapids—Incumbent
        C. I. Owen, M.D., Detroit—Incumbent
    (c) Alternate Delegates to American Medical Association
        W. W. Babcock, M.D., Detroit—Incumbent
        O. J. Johnson, M.D., Bay City—Incumbent
        E. F. Sladek, M.D., Traverse City—Incumbent
    (d) President-Elect
    (e) Speaker of the House of Delegates
    (f) Vice Speaker of the House of Delegates
35. **Adjournment**

ANNUAL SESSION APPOINTMENTS

Chairman of Arrangements

James W. Logie, M.D., Grand Rapids

House of Delegates Press Relations Committee

K. H. Johnson, M.D., Lansing, Chairman
L. Fernald Foster, M.D., Detroit
J. J. Lightbody, M.D., Detroit
C. Allen Payne, M.D., Grand Rapids
D. W. Thorup, M.D., Benton Harbor

Scientific Press Relations Committee

H. G. Benjamin, M.D., Grand Rapids, Chairman
F. S. Alfenito, Jr., M.D., Grand Rapids
N. L. Avery, Jr., M.D., Grand Rapids
A. B. Gwinn, M.D., Hastings
C. L. Weston, M.D., Owosso

HOTEL RESERVATIONS
MICHIGAN STATE MEDICAL SOCIETY

94th Annual Session

Grand Rapids, September 27-October 2, 1959

The reservation blank below is for your convenience in making your hotel reservation in Grand Rapids. Please send your application to Jack Ament, Secretary, Committee on Hotels for MSMS Convention, Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

— — — — — — — — — — — — — — — — — —

Jack Ament, Secretary
Committee on Hotels,
Michigan State Medical Society
c/o Pantlind Hotel
Grand Rapids, Michigan

Please make hotel reservation(s) as indicated below:

_____ Single Room(s) _____ persons

_____ Double Room(s) for _____ persons

_____ Twin-Bedded Room(s) for _____ persons

Arriving September _____ hour _____ A.M. _____ P.M.

Leaving _____ hour _____ A.M. _____ P.M.

Hotel of First Choice: _____

Second Choice: _____

Names and addresses of all applicants including persons making reservations:

Name	Address	City	State

Date _____ Signature _____

Address _____ City _____

MSMS HOUSE OF DELEGATES, 1959

Delegates and Alternates

(Names of Alternates appear in italics)

OFFICERS
K. H. Johnson, M.D., 1116 Mich. Nat'l Tower, Lansing
Speaker
J. J. Lightbody, M.D., 501 David Whitney Bldg., Detroit
Vice Speaker
L. Fernald Foster, M.D., 441 E. Jefferson, Detroit
Secretary
G. W. Slagle, M.D., 203 N.E. Capitol, Battle Creek
Immediate Past President
A. Verne Wenger, M.D., 132 Grand Ave. N.E., Grand Rapids
Honorary Member

ALLEGAN
Lewis F. Brown, M.D., 133 E. Allegan, Otsego
Elwin B. Johnson, M.D., 144 Brady St., Allegan

ALPENA-ALCONA-PRESQUE ISLE
Elbert S. Parmenter, M.D., Box 192, Alpena
John W. Bunting, M.D., 110 N. First Ave., Alpena

BARRY
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Robert J. Huebner, M.D., 234 E. State St., Hastings

BAY-ARENAC-IOSCO
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Stanley A. Cosens, M.D., 101 W. John St., Bay City
William G. Gamble, Jr., M.D., 2010 Fifth St., Bay City
Edward R. Rodda, M.D., 101 W. John St., Bay City

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Robert M. Leitch, M.D., 304 N. Broadway, Union City

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K. S. Wemmer, M.D., 1472 W. Michigan Ave., Battle Creek

CASS
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Uriah M. Adams, M.D., Marcellus

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Earl S. Rhind, M.D., Sault Polyclinic, Sault Ste. Marie

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James M. Grost, M.D., 110 Oakland St., St. Johns

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Earl R. Addison, M.D., Crystal Falls

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R. E. Landick, Jr., M.D., 111 S. Cochran St., Charlotte

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Clifford W. Colwell, M.D., 328 S. Saginaw, Flint 2
Lawrence G. Bateman, M.D., 1928 Lewis St., Flint 6
Franklin W. Baske, M.D., 923 Maxine St., Flint 3
William F. Buchanan, M.D., 238 W. Caroline, Fenton
Ernest P. Griffin, Jr., M.D., 503 S. Saginaw, Flint 2
Jesse L. Leach, M.D., 3007 Industrial Ave., Flint 5
David McTaggart, M.D., 312 Patterson Bldg., Flint 2
Harvey V. Sparks, M.D., 460 S. Saginaw, Flint 2

GOGEBIC
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Florian J. Santini, M.D., 109 E. Aurora St., Ironwood

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Charles E. Lemen, M.D., 110 S. Madison, Traverse City

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Richard E. Campbell, M.D., Ionia

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Charles R. Lenz, M.D., 405 First St., Jackson

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V. A. Notier, M.D., 50 College Ave. S.E., Grand Rapids
R. H. Puite, M.D., 26 Sheldon Ave. S.E., Grand Rapids

†Dr. Schneider has transferred from the state. An Alternate will be properly certified to take his place.

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Edward N. Elmendorf, II, M.D., Vassar

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Sidney E. Chapin, M.D., 125 N. Military, Dearborn 7
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William J. Coulter, M.D., 5258 Chatsworth, Detroit 24
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James D. Fryfogle, M.D., Medical Concourse, Northland Center, Detroit 35
Hugh M. Fuller, M.D., 1553 Woodward Ave., Detroit 26
Perry C. Gittins, M.D., 20210 Renfrew Ave., Detroit 21
Hugh W. Henderson, M.D., 17830 E. Warren, Detroit 24
Joseph Hickey, M.D., 6004 W. Fort St., Detroit 9
Homer A. Howes, M.D., 9322 Artesian, Detroit 28
Philip J. Huber, M.D., 1724 Bassett, Royal Oak
Louis Jaffe, M.D., 18662 Muirland, Detroit 21
R. J. Kokowicz, M.D., 19440 Van Dyke, Detroit 34
Earl G. Kreig, M.D., 85 Kercheval Ave., Detroit
A. M. Large, M.D., 1553 Woodward Ave., Detroit 26
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Arthur B. Levant, M.D., 15715 E. Warren, Detroit 24
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Harry F. Dibble, M.D., 1553 Woodward Ave., Detroit 26
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Russell F. Fenton, M.D., 15125 Grand River, Detroit 27
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Guy W. Sewell, M.D., 17751 E. Warren Ave., Detroit
William La Rue Sherman, M.D., 10 Peterboro, Detroit
J. W. Sigler, M.D., 1356 Greenlawn Blvd., Birmingham
H. L. Smith, M.D., 16401 Grand River Ave., Detroit 27
Carl J. Sprunk, M.D., 2900 Oakwood Blvd., Melvindale
R. V. Walker, M.D., 1553 Woodward Ave., Detroit 26
S. S. Wittenberg, M.D., 2306 Oakman Blvd., Detroit 38
D. A. Young, M.D., 14807 W. McNichols Rd., Detroit 35
Donald C. Young, M.D., 1151 Taylor, Detroit 2

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Michigan's Department of Health

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VENEREAL DISEASE IN MICHIGAN

In 1958, 4,267 cases of syphilis and 8,621 cases of gonorrhea were reported to the Michigan Department of Health. On the average, about one case of infectious venereal disease was reported every fifty-eight minutes, every day of the year. On the basis of these figures alone, venereal disease ranks by far the most frequently reported major communicable disease in Michigan.

But these figures reflect only a small part of the total problem. A recent survey made by the Department indicates that there is anywhere from five to ten times as much gonorrhea occurring and being treated as being reported. This suggests that there are anywhere from 40,000 to 80,000 cases of gonorrhea in Michigan today. Perhaps most serious, it is estimated that at this moment there are more than 58,000 Michigan persons with syphilis who are in need of treatment.

Any analysis of this problem must take into consideration the additional fact that venereal disease is primarily and initially a disease of young people. When we realize that these diseases affect those who have their greatest productivity still ahead, we can better understand the seriousness of the problem. The tragic part of it is that venereal disease is a needless disease. It is a preventable disease and even when not prevented it can be quickly diagnosed and effectively treated if found in time.

It is obvious that there remains an enormous gap between our knowledge and our application of that knowledge in the control of venereal diseases. What is needed to help bridge this gap? First of all, a clear understanding by the people, the patients, the health officers and the private physicians, that the venereal disease problem is serious and extensive. Second, we need more effective implementation of practical and sound objectives aimed at the control and eradication of this disease.

The four main objectives in a venereal disease control program are:

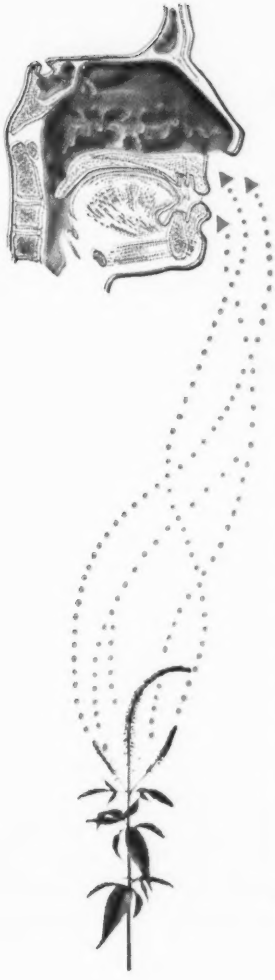
1. *Adequate Medical Attention for All Infected Persons.*—This must be the first objective because only through good medical care can the health of the patient be protected, the danger of the spread of infection be removed, and the disabilities which are so costly to patient and public alike be avoided.

2. *Casefinding.*—In the last ten years, there has been a 66 per cent decrease in the number of reported cases of early latent syphilis and a 93 per cent decrease in the number of reported cases of primary and secondary syphilis. Effective casefinding depends upon: (a) adequate reporting; (b) exhaustive epidemiological investigations by both health department and private physicians; (c) routine serologic testing for syphilis in industry, hospitals, and in private medical practice.

3. *Protection of Michigan Babies from Venereal Disease.*—This requires adequate follow-up of expectant mothers who have a reactive serology followed by adequate treatment of those mothers and children found suffering from venereal disease.

4. *Health Education.*—Ultimately effective control of venereal disease depends upon public understanding. This can be accomplished most effectively through the parents and the schools. In addition, professional education is needed through the schools of medicine and nursing, and through consultation to any physician requesting it.

It is possible with our present knowledge practically to eradicate the venereal diseases in Michigan. However, this will not be done until there are adequate medical and public health facilities to insure that every case of infectious venereal disease is found and treated. This, in turn, depends upon a well-informed public that knows how venereal disease occurs, how it spreads, and how it can be treated and cured.



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References: 1. Sheldon, J. M.: Postgrad. Med. **14**:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy **19**:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly **37**:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. **112**:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958.

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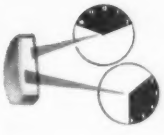

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In Memoriam

FRANK H. BETHEL, M.D., fifty-six, professor of internal medicine at the University of Michigan, died April 21, 1959.

Born in New York City, Doctor Bethel received a Bachelor of Arts from Princeton University in 1925, attended Cambridge University, England, for two years, and received his Doctor of Medicine from Johns Hopkins University in 1929.

In addition to being a professor at the University of Michigan, Doctor Bethel was director of the Simpson Memorial Institute at the University.

He was a member of the Central Society for Clinical Research, American Society for Clinical Investigation, Michigan Academy of Science, Arts and Letters, Phi Beta Kappa, and Sigma Chi.

DAVID BURLEY, M.D., ninety-five, Almont physician, died April 21, 1959.

Doctor Burley, one of Michigan's oldest practicing physicians, was a graduate of the former Detroit College of Medicine. The former Ontario farm boy began practicing medicine in 1893 in Almont, and continued his practice sixty-five years until his last illness. Almont observed "Doctor Burley Week" in 1953. Doctor Burley was a constant registrant at MSMS Annual Sessions and at Michigan Clinical Institutes and a lifetime advocate of postgraduate medicine.

ARTHUR J. CARLTON, M.D., seventy-eight, Upper Peninsula physician, died March 31, 1959. Born in Jamestown, N. Y., Doctor Carlton received his medical degree at the University of Michigan in 1904.

He practiced in Rapid River, where he established a hospital, and in Gladstone before moving to Escanaba in 1909.

Doctor Carlton was past president of the Delta-Schoolcraft County Medical Society, past president of the Escanaba Board of Education and a member of the St. Stephen's Episcopal Church.

ROBERT F. JAENICHEN, M.D., sixty-two, Saginaw orthopedic surgeon, died March 31, 1959.

A native of Detroit, Doctor Jaenichen attended the University of Michigan and was graduated in 1922 from Wayne University Medical School.

He was the inventor of a metallic hip joint which has been used to ease the pain and often restore mobility of persons disabled by diseased or fractured hip bones.

Doctor Jaenichen was a senior staff member of St. Luke's hospital, and a member of Knights Templar, Civitan Club and Jefferson Avenue Methodist Church, all of Saginaw.

(Continued on Page 990)

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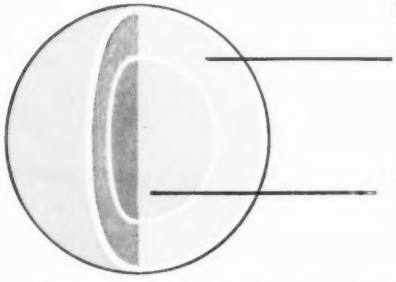
the diagnosis: any one of several nonspecific gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy. **the prescription:** a new formulation, incorporating in a single tablet the actions of Donnatal and Entozyme. **the dosage:** two tablets three times a day, or as indicated.



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(Continued from Page 988)

HARTMAN A. LICHTWARDT, M.D., sixty-six, Detroit surgeon, died April 28, 1959.

A native Detroiter, Doctor Lichtwardt was a graduate of Wayne State University School of Medicine and served with the U. S. Army Medical Corps in World War I.

In 1919 he was attached to the American Christian Hospital in Meshed where he started the first work among lepers in Iran.

In 1925, he had the distinction of being one of the few physicians ever ordained to the Presbyterian ministry.

Returning to Detroit in 1942, he joined the surgical staff at Ford Hospital. From 1946 until his retirement in 1958, Doctor Lichtwardt was medical director of Women's Hospital in Detroit.

In other fields, Doctor Lichtwardt was president of the Detroit branch of the Foreign Policy Association, chairman of the board of the World Study Council and a member of the Detroit Committee on Foreign Relations and the Economic Club of Detroit.

Interested in alcohol education, he also served with the Detroit Committee on Alcoholism and on the Michigan State Board of Alcoholism.

GORDON McKILLOP, M.D., sixty-four, practicing Gaylord physician, died March 24, 1959.

Doctor McKillop practiced medicine in Gaylord for thirty-two years. He was a life-long booster of sports, serving as athletic director of Tarkio College in Missouri, before enrolling in the University of Western Ontario at London, Ontario, where he received his medical degree in 1924.

He had been the chief of staff at the Otsego Memorial Hospital since its inception.

Doctor McKillop was a charter member and past president of the Gaylord Kiwanis Club, past president of the Youth Activities Club, a member of the Order of Eagles, Gaylord Country Club, and the Gaylord Fishing Club.

EUGENE H. RONEY, M.D., fifty-one, a Detroit practicing physician for twenty-five years, died April 10, 1959.

Doctor Roney was a graduate of Assumption College, the University of Detroit and Wayne State University School of Medicine.

He served as an army major in World War II.

FORDYCE H. STONE, M.D., seventy-one, a practicing physician in Beulah for forty-five years, died April 9, 1959.

Doctor Stone was a graduate of the Hering Medical College in Chicago.

He was active in civic and business affairs in his community. He was a former chairman of the board of directors of the Benzie Company, served on the board of directors of the Central State Bank and was vice president at the time of his death and also a member of the Benzonia Masonic lodge.

. . . . . NEWS MEDICAL

MICHIGAN AUTHORS

George H. Agate, M.D., East Lansing, is the author of an article entitled "Prevention of Staphylococcal Infections in Newborn Infants," published in THE JOURNAL of the Michigan State Medical Society, June, 1958, and digested in *Digest of Ophthalmology and Otolaryngology,* January-April, 1959.

Conrad L. Giles, M.D., Ann Arbor, is the author of an article entitled "Tonometer Tensions in the Newborn," published in *Archives of Ophthamology,* April, 1959.

David Barsky, M.D., Detroit, is the author of an article entitled "Keratomycosis, A Report of Six Cases," published in *Archives of Ophthalmology,* April, 1959.

Russell N. De Jong, M.D., Ann Arbor, is the author of an article entitled "The Treatment of Vascular Headaches," published in *GP,* April, 1959.

Merle Lawrence, Ph.D., Robert D. Burton, M.D., and **David Wolsk, M.A.,** Ann Arbor, are the authors of an article entitled "Acoustics of the Opened Periotic Vestibule," published in A.M.A. *Archives of Otolaryngology,* April, 1959.

Alexander P. Kelly, Jr., M.D., Detroit, is the author of an article entitled "Subtotal Reconstruction of the Thumb," published in A.M.A. *Archives of Surgery,* April, 1959.

Joseph C. Sieracki, M.D., and **Alex P. Kelly, Jr., M.D.,** Detroit, are the authors of an article entitled "Traumatic Epidermoid Cysts Involving Digital Bones," published in A.M.A. *Archives of Surgery,* April, 1959.

Earl F. Wolfman, Jr., M.D., and **D. E. Boblitt, M.D.,** Ann Arbor, are the authors of an article entitled "Intramural Aortic Dissection as a Complication of Translumbar Aortography," published in A.M.A. *Archives of Surgery,* April, 1959.

A. D. Ruedemann, Jr., M.D., Detroit, is the author of an article entitled "The Electroretinogram in Hereditary Visual Cell Degeneration," presented at the Sixty-Third Annual Session of the American Academy of Ophthalmology and Otolaryngology, October, 1959, Chicago, and published in *Transactions of the American Academy of Ophthalmology and Otolaryngology,* March-April, 1959.

Fred W. Whitehouse, M.D., Detroit, is the author of an article entitled "Current Status of Chlorpropamide in Management of Diabetes Mellitus," published in *Henry Ford Hospital Medical Bulletin,* March, 1959.

William O'Driscoll, M.D., Joseph Sieracki, M.D., and **William S. Haubrich, M.D.,** Detroit, are the authors of an article entitled "The Particulate Absorption of Fat: Its Direct Demonstration in a Normal Human," published in the *Henry Ford Hospital Medical Bulletin,* March, 1959.

Brock E. Brush, M.D., John H. Wylie, Jr., M.D., Melvin A. Block, M.D., Joseph Beninson, M.D., and **John J. Spitzer, M.D.,** Detroit, are the authors of an article entitled "A Device for the Prevention of Phlebothrombosis and Pulmonary Embolism," published in the *Henry Ford Hospital Bulletin,* March, 1959.

W. W. Ackermann, M.D., Ann Arbor, is the author of an article entitled "Certain Factors Governing the Persistence of Poliovirus in Tissue Culture," from a Symposium on Latency and Masking in Viral and Rickettsial Infections, proceedings of a conference held at the University of Wisconsin Medical School, September, 1957, and listed in *Current Literature on Poliomyelitis and Related Diseases,* January, 1959.

David J. Sandweiss, M.D., Marcus H. Sugarman, M.D., and **Jack M. Kaufman, M.D.,** Detroit, are the authors of an article entitled "Do Ulcer Diets Promote Coronary Heart Disease in Peptic Ulcer Patients?", published in *Harper Hospital Bulletin,* January-February, 1959. The authors were assisted by Marion E. Mann, B.Sc., Department of Dietetics.

Melvin L. Selzer, M.D., and **Herbert Waldman, M.A.,** Ann Arbor, are the authors of an article entitled "The Use of Doxylamine in Schizophrenia: Pitfalls in the Evaluation of a New Drug," published in the *Journal of Nervous and Mental Disease,* December, 1958.

Melvin L. Selzer, M.D., Ann Arbor, is the author of an article entitled "On Involuntary Hospitalization for Alcoholics," published in *Quarterly Journal of Studies on Alcohol,* December, 1958.

R. V. August, M.D., Muskegon Heights, is the author of an article entitled "The Obstetrician and Hypnosis," presented at the first annual meeting of the American Society of Clinical Hypnosis, October, 1958, and published in *The American Journal of Clinical Hypnosis,* April, 1959.

Edgar E. Poos, M.D., Detroit, is the author of an article entitled "Stress Factors in Rhinology," read before the Sixth International Congress of Otolaryngology, Washington, D. C., May, 1957, and published in *Annals of Otology, Rhinology and Laryngology,* December, 1958.

Martin J. Urist, M.D., South Haven, is the author of an article entitled "The Etiology of the A and V Syndromes," published in the *American Journal of Ophthalmology,* December, 1958.

George W. Lechner, M.D., and **Paul J. Connolly, M.D.,** Detroit, are the authors of an article entitled "Benign Neoplasms of the Small Intestine with a Report

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of Three Bleeding Benign Tumors of the Jejunum," published in the *Journal of the American Medical Association*, April 25, 1959.

Harold F. Falls, M.D., Ann Arbor, is the author of an article entitled "Ophthalmology as a Vocation," published in *The New Physician*, March, 1959.

W. S. Reveno, M.D., and **H. Rosenbaum, M.D.,** Detroit, are the authors of an article entitled "Long Term Effects of Corticosteroid Therapy," presented before the Detroit Academy of Medicine, January 13, 1959, and published in *Harper Hospital Bulletin*, January-February, 1959.

K. L. Krabbenhoft, M.D., and **R. C. Thumann, M.D.,** Detroit, are the authors of an article entitled "The I^{131} Diodrast Renogram for Evaluation of Kidney Function in Hypertension," published in *Harper Hospital Bulletin*, January-February, 1959.

Robert C. Mochlig, M.D., Detroit, is the author of an article entitled "Harper Hospital Profiles: Dr. Max Ballin," published in *Harper Hospital Bulletin*, January-February, 1959.

C. J. Tupper, M.D., and **M. B. Beckett, M.D.,** Ann Arbor, are the authors of an article entitled "Faculty Health Appraisal, The University of Michigan: Second Annual Report," published in *The University of Michigan Medical Bulletin*, January, 1959.

Ralph F. Knopf, M.D., and **C. William Castor, M.D.,** Ann Arbor, are the authors of an article entitled "Systemic Lupus Erythematosus in an Elderly Patient: A Case Report," published in the *University of Michigan Medical Bulletin*, January, 1959.

J. Frederic Johnson, M.D., Detroit, is the author of an article entitled "Intravenous Estrogens and Certain Factors in Blood Coagulation," published in *Clinical Medicine*, April, 1959.

Leopold Liss, M.D., Ann Arbor, is the author of an article entitled "Histopathology of Olfactorius Duc to Sarcomatosis of the Meninges," published in A.M.A. *Archives of Otolaryngology*, February, 1959.

Justine L. Vaughen, M.D., and **Leonard F. Bender, M.D.,** Ann Arbor, are the authors of an article entitled "Effects of Ultrasound on Growing Bone," read at the Thirty-sixth Annual Session of the American Congress of Physical Medicine and Rehabilitation, Philadelphia, August, 1958, and published in *Archives of Physical Medicine and Rehabilitation*, April, 1959.

Joseph G. Molner, M.D., M.P.H., Jacob A. Brody, M.D., and **George H. Agate, M.D.,** Detroit, are the authors of an article entitled "Detroit Poliomyelitis Epidemic—1958," published in the *Journal of the American Medical Association*, April 18, 1959.

William H. Beierwaltes, M.D., Ann Arbor, is the author of an article entitled "The Clinical Radioisotope Unit and Alice Crocker Lloyd Memorial Laboratory," published in the *University of Michigan Medical Bulletin*, February, 1959.

Norman D. Henderson, M.D., Lansing, **Fred C. Garlock, M.D.,** Grand Ledge, and **Birger H. Olson, Ph.D.,**

(Continued on Page 996)

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Lansing, are the authors of an article entitled "Treatment of Acute Typhoid with Synnematin B," published in the *Journal of the American Medical Association*, April 25, 1959.

J. S. DeTar, M.D., Milan, is the author of an article entitled "Your Medical Practice in 1970, You Will Be More of a Family Physician," published in *The New Physician*, May, 1959.

Stewart N. Nickel, M.D., and **Henry H. Gale, M.D.,** Detroit, are the authors of an article entitled "Altered Prognosis with Cardiac Massage," published in the *Journal of the American Medical Association*, May 2, 1959.

Samuel J. Levin, M.D., Detroit, is the author of an original article "Management of the Acute Attack of Asthma in Childhood with Special Reference to Steroid Therapy," in the April issue of the A.M.A. *Journal of Diseases of Children.*

* * *

A one-day conference on "The Physicians Role in Mental Retardation" sponsored by the Child Welfare Committee of MSMS, the Department of Maternal and Child Health of the Michigan Department of Health in co-operation with the University of Michigan Medical School, will be held beginning at 8:30 a.m. in Room 5406 of the Main Hospital of the University of Michigan at Ann Arbor on Monday, June 29, 1959.

The American Academy of Ophthalmology and Otolaryngology will hold its annual session at the Parker House, Chicago, October 11-16, 1959. It has also arranged a very attractive program of clinics in Mexico, October 17 to 23, 1959.

* * *

John W. Smillie, M.D., Ann Arbor, was the guest speaker at the meeting of the Saginaw Valley Ophthalmological Society on May 5, 1959, at the High Life Inn in Saginaw.

* * *

The Journal of the Michigan State Medical Society for the year 1958 has been placed upon microfilm. Anybody wishing to economize on storage space to use THE JOURNAL as reference or libraries may obtain the microfilm roll. This consolidates a large bulky volume in one very small 37mm roll and will surely be a great convenience. Information may be obtained through our business office in Lansing.

* * *

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, Part I, and requests for re-examination Part II are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is August 1, 1959. No applications can be accepted after that date.

Candidates are requested to write to the office of the

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Secretary for a current Bulletin, if they have not done so, in order that they may be well informed as to the present requirements. Application fee ($35.00), photographs, and lists of hospital admissions must accompany all applications. Address Robert L. Faulkner, M.D., Secretary, 2105 Adelbert Road, Cleveland 6, Ohio.

* * *

U OF M MEDICAL CENTER

Here is a missile's eye view of the University of Michigan Medical Center which was displayed recently to doctors of medicine at a special open house on Doctor's Day. The day-long program featured special exhibits, lectures, clinical tours and closed circuit TV broadcasts of surgical techniques. Two MSMS officials were co-chairmen of Doctor's Day, President G. B. Saltonstall, M.D., Charlevoix, and President-elect M. A. Darling, M.D., Detroit.

* * *

The American College of Gastroenterology announces that its annual course in Postgraduate Gastroenterology will be given at The Biltmore in Los Angeles, California, on September 24, 25 and 26, 1959.

The faculty for the course will be drawn from the medical schools in and around Los Angeles. The subject matter to be covered in the course, from a medical as well as surgical viewpoint, will be essentially the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gall bladder, colon and rectum. There will be a clinical session at the College of Medical Evangelists and this year, in addition to individual papers, there will be several panel discussions of interest.

For further information and enrollment, write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

* * *

The National Library of Medicine has just issued *Fungus Infections,* a bibliography on systemic and superficial fungus infections. This is another in its series of selective bibliographies on subjects of current interest. Others in the series are on space medicine, cancer chemotherapy, and staphylococcal infections. A complete list of such bibliographies is available. Single copies of the bibliographies can be obtained at no cost upon request to the: Acquisition Division, National Library of Medicine, 7th Street & Independence Ave. S.W., Washington 25, D. C.

* * *

In recognition of World Mental Health Day, April 7, 1959, the Department of Psychiatry of Wayne State University College of Medicine held an open staff meeting. The observation of World Mental Health Day consisted in the designation of certain special research and development projects to be advanced in 1960. This is in harmony with the resolution of the World Federation Organization of Mental Health, a United Nations Agency. John M. Dorsey, M.D., Professor and Chairman of the Department, named the following projects selected by the staff for special emphasis:

1. The problem of child care and the psychological aspects of education as well as the psychiatric education of medical students.

2. The mental health of the college student.

3. Problems of convalescence, vocational rehabilitation and the psychological aspects of industrial medicine.

4. Problems of migration and the migratory worker.

5. Problems of addiction, including alcoholism and the industrial aspects of it.

6. Problems of depression and suicide, with special reference to the rescue fantasy.

These projects, which are conducted by various members of the Department of Psychiatry, have been designated for special effort during the World Mental Health Year (1960). Their nature is mostly inter-disciplinary, involving not only the Department of Psychiatry and the Detroit Receiving Hospital, but also other colleges and organizations interested in mental health.

* * *

"MD International," a medical program, was honored Tuesday, April 7 as the television show which contributed most to international understanding during 1958, at the annual presentation of the coveted Peabody Awards for outstanding accomplishments in television.

The hour-long color documentary, most recent of the "March of Medicine" series sponsored by Smith Kline & French Laboratories, showed American physicians abroad in their dual role as men of medicine and unofficial ambassadors of the United States as they practice at the "bedside of the world." The doctors were seen at work at outposts in Korea, Hong Kong, Borneo, Burma, Nepal, Lebanon, Ethiopia, and India.

The program presented in co-operation with the American Medical Association, was inspired by President Eisenhower's appeal for "People-to-People" activities in all professions and walks of life as a keyway to further international understanding. "MD International" was selected to receive the George Foster Peabody Award for "outstanding contribution to international understanding." Dean John E. Drewry of the University of Georgia's Henry W. Grady School of Journalism which sponsors the awards, made the presentation to Joseph N. DuBarry, Assistant to the President of Smith Kline & French Laboratories, at a luncheon meeting of the Radio and Television Executives Association.

The "March of Medicine" series has been produced

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by SKF Laboratories in co-operation with the American Medical Association as a public service since 1952. It was the first television series to receive an Albert Lasker Award for medical journalism.

* * *

Memorial Phoenix Project.—The University of Michigan has launched a campaign to raise $2,000,000 for its Memorial-Phoenix Project for atomic research.

At a meeting of 104 state business and industrial leaders Wednesday, April 1, campaign and project officials outlined the results of Phoenix research over the past 10 years, and described the needs of the future.

James C. Zeder, Chrysler Corporation vice-president and campaign committee chairman, told the group that funds raised to establish the project in 1948 as a memorial to the U-M's World War II dead are nearly exhausted.

Zeder said the $2 million would pay for five more years of research on the peaceful applications and implications of atomic energy.

A total of $8 million was contributed by University students, alumni, friends and industrial groups to start the Phoenix Project. The money has been used to build a million-watt nuclear reactor and modern research facilities, to support 185 research projects, to buy equipment, to free scientists for full-time investigations, and to provide information about the atomic energy field.

The Phoenix Project is "the largest independent atomic research program in the world." It operates the nation's most powerful college nuclear reactor, has brought about the country's largest enrollment in nuclear engineering and science at the U-M, and has sent people to help twenty other nations set up their own peaceful A-energy programs.

Dr. Henry J. Gomberg, the project's assistant director, noted that Phoenix's independent position enabled it to help strip the secrecy away from atomic energy activities. Over 300 technical publications have resulted from Phoenix-supported research. Ten years ago, one room in the University Hospital was set aside for the use of radioactive materials in diagnosis and therapy; a twenty-four room suite is now required, and all U-M medical students receive full training in the new techniques.

* * *

Medical educators from fifty different countries will gather in Chicago for the Second World Conference on Medical Education, August 29 to September 4, jointly sponsored by the great world bodies of medicine, and will provide a common ground for the free exchange of scientific information and experiences between countries. The conference is being held under the auspices of the World Medical Association, which was founded twelve years ago and is now composed of fifty-five national medical associations representing about 700,000 physicians.

Collaborating with the World Medical Association in sponsoring the Chicago conference are the World Health Organization, the Council for International Organizations of Medical Sciences, and the International Association of Universities.

This second conference will give medical educators an

opportunity to examine the progress that has been made during the five-year interval in extending medical education—the real basis of all medical care—and raising its standards.

Between 1,500 and 2,000 persons from all over the world will attend the conference; there will be 125 speakers from about fifty countries, and all business, including lectures, will be translated simultaneously into English, French, and Spanish.

* * *

Albert D. Ruedemann, M.D., of Wayne State University College of Medicine received the Lucien Howe Award from the University of Buffalo Thursday, April 9, 1959, for his noteworthy contributions to ophthalmology. Presentation was made by Clifford C. Furnas, chancellor of the University at a meeting of the Buffalo Ophthalmological Club. The Howe award is given annually to an outstanding ophthalmologist.

Dr. Ruedemann is professor and chairman of the department of ophthalmology and Director of Kresge Eye Institute. He also heads the departments of ophthalmology at Detroit Receiving and Harper hospitals. He graduated from the University of Michigan medical school in 1923. He was certified as a specialist by the American Board of Ophthalmology and Otolaryngology in 1929. He organized and headed the department of ophthalmology at the Cleveland Clinic for twenty-three years.

In 1947, Dr. Ruedemann came to Detroit to head the ophthalmology department at Wayne State. The Kresge Foundation asked him to organize an eye institute in 1948. The Kresge Eye Institute, located on the University Medical Campus adjacent to Detroit Receiving and Detroit Memorial hospitals, has become internationally known through its educational and research program on diseases of the eye.

* * *

State Indigent Patient Care Suspended.—University Hospital, a self-supporting unit of The University of Michigan Medical Center, has refused to accept patients from state institutions except in emergencies. The action followed when the state fell more than $500,000 behind in payments for the care of its medically indigent. Affected are patients from state institutions at Lapeer, Coldwater, Caro and Northville; others from the Girl's Training School at Adrian; The Michigan's Children's Institute, Ann Arbor; and cases falling under the Michigan Crippled Children's Commission.

University Hospital is the second major hospital in Michigan forced to suspend care to the state. Detroit Children's Hospital took the step early this year. Michigan has long been a leader in the nation in the care of its medically indigent. But individual self-supporting hospitals are unable to assume the burden which voters have assigned to the state itself.

Over the past ten years, University Hospital has lost $895,000 through actual services rendered to the Michigan Crippled Children's Commission alone. If current charges to the Commission go unpaid, this figure will reach $1,147,000. Most of the loss is accounted for by an arbitrary ceiling placed on medical care by the legislature.

H. Marvin Pollard, M.D., of the University of Michigan Medical Center, was elected a Regent of the American College of Physicians at the Association's annual session in Chicago. He has served as Michigan Governor of the American College of Physicians since 1953.

* * *

COUNTY SOCIETIES HONOR SCIENCE FAIR WINNERS

Students winning best of show for their medical exhibits at the recent Metropolitan Detroit Science Fair were honored jointly by the Macomb, Oakland, and Wayne County Medical Societies. Pictured above is Milton R. Weed, M.D., president of WCMS, presenting a Certificate of Merit to a happy winner.

* * *

A new consulting and diagnostic service for multiple sclerosis patients has been established at Wayne State University's College of Medicine. The clinic was made possible by a $20,000 grant from the Michigan chapter of the National Multiple Sclerosis Society, a United Fund-Torch Drive Agency. John T. McHenry, M.D., associate professor of neurology, has been appointed director of the clinic.

Research projects into the cause of multiple sclerosis, a disease of the central nervous system, will also be conducted by the department of neurology. Under the terms of the Society's affiliation, the department of neurology will provide neurological supervision and clinical evaluations for the referring physician. The ultimate responsibility for patient care rests with the family physician.

Physical therapy and related treatments will be administered at the Rehabilitation Institute of Metropolitan Detroit and other community agencies.

* * *

Group Health Insurance, Inc., of New York City, and the Federal government are collaborating in an experimental project whose possibilities are unlimited. National Institute of Mental Health has granted GHI $300,000 to help finance a two-year program designed to combat mental illness with preventive medicine through medium

of prepayment. In other words, government will subsidize private, voluntary health insurance so that it may broaden benefits without increasing charges.

Over a two-year trial period, a cross-section of 30,000 GHI members in Greater New York will be entitled to psychiatric services in office and hospital at a fraction of the actual cost. Major part of the expense will be borne by the $600,000 special pool contributed in equal parts by GHI and National Institute of Mental Health.

Very few prepaid health insurance plans in force today, nonprofit or commercial, cover mental and nervous ailments or their prevention. Purpose of this new project is to determine feasibility of broadening benefits and ascertaining what premium costs would have to be.

* * *

The International College of Surgeons has announced that it will hold its fourth around-the-world postgraduate refresher clinic tour in the late Fall. Edward L. Compere, M.D., of Chicago, president of the United States Section, ICS, will be the co-ordinator of medical activities.

Departure will be by plane from San Francisco, October 10. The tour participants will take in specially arranged meetings of ICS Sections in Tokyo, October 18-19; Hong Kong, October 29-30; Bangkok, November 2; Tel Aviv, November 20; Istanbul, November 24, and Athens, November 27.

Sightseeing trips have been arranged for these and other countries, including Thailand, India, Ceylon, Egypt, Lebanon, and Jordan. Arrival in New York will be about December 1. Accommodations are limited.

For further information, write to the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, or to the International Travel Service, Inc., 119 South State Street, Chicago 3.

* * *

The University of Michigan physicist's "bubble chamber" is regarded as one of the major developments in the field of nuclear physics since the end of World War II. The University has the nation's largest graduate program in nuclear science and engineering. University of Michigan botanists have found radioactive tracers an invaluable tool in their basic study of the ways plants select and absorb nutrients in the soil.

* * *

Wallace W. Tourtelotte, M.D., assistant professor of neurology at The University of Michigan Medical Center, received the S. Wier Mitchell Award at the annual meeting of the American Academy of Neurology, April 16, 1959, at Los Angeles, California. The $250 award acknowledged his original work on the chemistry of cerebrospinal fluid. It is given each year to a junior member of the Academy in recognition of his accomplishments and research.

Dr. Russell N. DeJong, chairman of the Department of Neurology, University of Michigan Medical Center, termed Dr. Tourtelotte's research "very original and

important." Dr. Tourtelotte was one of several University of Michigan scientists who recently analyzed the fatty content of normal spinal fluid for the first time. The discovery unlocked a new field of development in the laboratory study of the illusive disease, multiple sclerosis.

* * *

A second series of lectures sponsored by the Michigan Tuberculosis Association was introduced recently at Michigan State University. Called the Charles Maurice Yates Lectures, the first of this series was delivered by Dr. Charles L. Hudson, professor of medicine at the Western Reserve University Medical School, Cleveland, Ohio. Speaking before a Conference on Medical Writing for the Mass Media, Hudson discussed "Science Writers and Doctors."

Doctors and science writers must have an opportunity to meet and talk, to promote understanding of each other's problems, to generate respect each for the other, and to recognize the rights of individuals, of writers, of doctors, and of the public, Hudson stated.

Another lecture series, the Henry Brooks Baker Lectures, have been sponsored by the Michigan Tuberculosis Association since 1952. They are given annually in December before the School of Public Health, University of Michigan.

* * *

The American College of Obstetricians and Gynecologists, at its seventh annual meeting, April 6-8, 1959, in Atlantic City, selected a Michigan member, C. Paul Hodgkinson, M.D., of Henry Ford Hospital, Detroit, as President-elect. Dr. Hodgkinson is a graduate in Pharmacy, University of Pittsburgh, 1925; and a graduate in Medicine, Temple University, 1936. He took postgraduate work at the University of Michigan, receiving his M.S. degree in obstetrics and gynecology.

* * *

An all alumni-faculty scientific program featured the 91st alumni reunion and clinic day of Wayne State University College of Medicine, Wednesday, May 13. More than 200 graduates attended both the science section and dinner dance at the Hotel Fort Shelby. The science program began at 9:30 a.m. and included sections on surgery, medicine, pathology, anesthesiology, obstetrics and gynecology, radiology and psychiatry.

Theodore I. Bergman, M.D., president of the medical alumni, presided and Duncan H. Cameron, M.D., Farmington, was program chairman.

At the banquet Wednesday evening, nine fifty-year graduates of the College of Medicine were given golden anniversary certificates by Dr. Osborne A. Brines, pro-

fessor and chairman of pathology. They are: Drs. Guy D. Briggs and Henry Cook, Flint; Dr. Alfred A. Wade, Howe, Indiana; Drs. Albert L. French, Euclid V. Joinville and Edward J. O'Brien, Detroit; Dr. William G. Coulter, Windsor; Dr. Burton L. Rockwell, Drickany Falls, N. Y.; and Dr. John C. Sanford Brown, Orange, California.

Distinguished service citations were presented at the banquet to Loren W. Shafer, M.D., and John E. Webster, M.D., both of Detroit.

Giving scientific papers were Drs. Leonard F. Vanraaphorst, C. Jackson France, Warren O. Nickel, Donald E. Economy, Saul Sakwa, Don W. McLean, Arnold R. Axelrod, Yoshikazu Morita, George C. Thosteson, Robert B. Leach, Rosser L. Mainwaring, Elmer R. Jennings, Edward T. Glowacki, Charles E. Darling, W. George Belanger, Benjamin Jeffries, Osborne A. Brines, Charles G. Johnson and Gordon B. Myers.

* * *

An exhibit on intravenous aortography and one on a study of the development of sensory cell innervation in the inner ear won the top awards for scientific exhibits at the ninth annual convention of the Student American Medical Association, May 1, 1959, in Chicago.

The scientific exhibit awards—called the SAMA-Lakeside awards—were presented to three senior medical students and three residents. The top award winners are Dr. Eugene F. Bernstein, a resident at the University of Minnesota Hospitals, and Conrad A. Proctor, a senior student at the University of Michigan.

The first prize consists of a plaque, $500, and the privilege of displaying the exhibit at the American Medical Association's annual meeting in Atlantic City, June 8-12. In addition, the two top winners were awarded an expense-free week during the AMA convention.

* * *

David I. Sugar, M.D., Detroit, was chosen President-elect of the Wayne County Medical Society at the annual meeting of May 4. Doctor Sugar will succeed President Milton R. Weed, M.D., in May, 1960. Hugh M. Fuller, M.D., was re-elected Secretary and Charles W. Sellers, M.D., was placed on the Board of Trustees.

* * *

Oliver B. McGillicuddy, M.D., Lansing, Councilor of the Second District of MSMS, was appointed by G. B. Saltonstall, M.D., Charlevoix, as the official MSMS representative for the Michigan Hospital Association's 1959 contest entitled "Annual Search For New Hospital Achievements." Besides the Michigan State Medical Society, one judge each will be representative of the University of Michigan; Michigan State University; Michigan Bell Telephone Company; Catholic Charities; Management; and the Citizens Research Council.

* * *

Austin Smith, M.D., former Editor of the *Journal of the American Medical Association*, has been elected as full time president of the Pharmaceutical Manufacturers Association. The PMA recently was reorganized by merging the American Drug Manufacturers Association and the American Pharmaceutical Manufacturers Association. Dr. Smith will be the first full time paid chief executive officer of the Association and will direct its destinies with the co-operation of its board of directors. His office will be at 503-7 Albe Bldg., Washington 5, D. C. Congratulations, Dr. Smith!

Russell T. Woodburne, M.D., University of Michigan School of Medicine, was selected to lead a sectional meeting at the first National Conference on the Legal Environment of Medical Science at the University of Michigan in May.

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John W. Rigterink, M.D., Grand Rapids, who is retiring after fifty-seven years of practice, was honored at the Grand Rapids Clark Home. He was presented a framed scroll in recognition of his thirty-eight years as physician for the Home.

* * *

Donald V. Sargent, Saginaw County Medical Society president, presented certificates to twenty-one Saginaw area high school pupils entering outstanding exhibits pertaining to medicine in the second annual Saginaw County Science Fair. The society honored the young people to encourage them to continue their pursuit of science.

* * *

An invitation to Michigan physicians to compete for two cash awards for original work in the fields of obstetrics and gynecology is extended by the American College of Obstetricians and Gynecologists, District V which includes Michigan. Papers describing original investigative or clinical work in the two fields are desired. Information may be obtained from Edwin S. Hoffman, M.D., 766 Fisher Building, Detroit 2.

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James Gerity, Jr., of Adrian, an advisory member of the MSMS Rheumatic Fever Control Committee, has been elected President of the Committee of One Hundred, succeeding the late Charles F. Kettering.

Congratulations, Mr. Gerity!

* * *

James E. Lofstrom, M.D., Detroit, has been awarded a $33,239 grant by the American Cancer Society. The award is for a one-year study of the effects of radiation on body functions. Doctor Lofstrom is past president of the Southeastern Michigan Division of the American Cancer Society.

* * *

The American Association of Blood Banks will hold its 12th annual meeting at the Edgewater Beach Hotel, Chicago, November 4-7, 1959. The conference theme will be "The Compleat Transfusion Service."

* * *

Arthur A. Humphrey, M.D., Battle Creek, has been presented the American Cancer Society's highest award to an individual by the Michigan division of ACS. He received the Tiffany Medal in recognition of his "important contribution to the control of cancer." Dr. Humphrey long has been active in the Calhoun County and Michigan Division cancer units and has written many papers about cancer and allied subjects.

* * *

The Arizona Pharmaceutical Association adopted a resolution recommending that druggists who customarily send Christmas gifts to physicians do so in the form of donations to the American Medical Education Foundation in the individual doctor's honor. In 1958, this approach resulted in contributions of $1,600 to AMEF in the names of physicians.

Several doctors spoke at the seventh annual Management Conference for County Medical Care Facilities and County Infirmaries. The speakers at this recent Michigan State University conference included Lester E. Wolcott, M.D., of Lansing, and James W. Rae, Jr., M.D., and Edwin M. Smith, M.D., both of Ann Arbor.

* * *

Vaughn Monroe, nationally-known entertainer, recently spoke at the Macomb-Oakland-Wayne cancer banquet at the Detroit Cancer Center. Mr. Monroe, whose family has been attacked three times by cancer, told the assembly: "People die directly of cancer, but indirectly of superstition, of indifference and of fear. Those are the enemies, and it is only through the efforts of you who know by experience that they can be defeated."

* * *

A. B. Aldrich, M.D., was co-chairman for the annual Copper Country Career Day at Houghton. About 500 Copper Country high school youths participated to get advice on careers in medicine and 15 other business and professional fields.

* * *

Walter H. Obenauf, M.D., of Ypsilanti, is the new president of the Michigan Society of Neurology and Psychiatry. He also is president of the Michigan Branch of the American Psychiatric Association.

* * *

The Muskegon County Medical Society has selected Arthur L. Benedict, M.D., as its new president-elect. Following the recent death of President Norman A. Fleischman, M.D., president-elect, L. L. Loder, M.D., was advanced to the presidency.

C. Paul Hodgkinson, M.D., Detroit, was named president-elect at the recent annual meeting of the American College of Obstetricians and Gynecologists in Atlantic City. Doctor Hodgkinson, who obtained his M.D. degree from Temple University School of Medicine, has taken postgraduate work at the University of Michigan Medical School and obtained his M.S. in obstetrics and gynecology.

* * *

Again this summer, July 29-August 15, the University of Southern California School of Medicine will offer a postgraduate refresher course in Honolulu and on board the *S.S. Lurline*. Pamphlets and information may be obtained from Director, Postgraduate Division, School of Medicine, University of Southern California, 2025 Zonal Avenue, Los Angeles 33, California.

* * *

U-M in National Study—The University of Michigan is one of 15 medical centers in the nation and Canada which will participate in a two-year epidemiological study of leukemia in childhood. This national co-operative leukemia study is sponsored by the National Cancer Institute. The Michigan study will consider children with leukemia and other malignancies who are admitted to the University Hospital during 1959 and 1960. Members of the project staff include Thomas Francis, Jr., M.D., Donald C. Smith, M.D., and Janice B. Vanderberg, B.S.N.

* * *

The Medical Advisory Committee of Michigan Hospital Service (Blue Cross) is composed of twelve doctors of medicine, each appointed for a three-year term.

Half the Medical Advisory Committee is composed of members of the Board of Trustees of Michigan Hospital Service; the other six are appointed by the Michigan State Medical Society.

The personnel of the Committee is as follows: *Trustee Members*—Wm. S. Reveno, M.D., Detroit, Chairman, E. C. Baumgarten, M.D., Detroit, O. O. Beck, M.D., Birmingham, Wm. M. LeFevre, M.D, Muskegon, James W. Logie, M.D., Grand Rapids, D. R. Smith, M.D., Iron Mountain. *Appointed Members*—Frank J. Busch, M.D., Saginaw, C. W. Colwell, M.D., Flint, L. Fernald Foster, M.D., Detroit, W. S. Jones, M.D., Menominee, R. L. Novy, M.D., Detroit, and Ralph W. Shook, M.D., Kalamazoo.

The purpose of the Medical Advisory Committee to Michigan's Blue Cross is to act as a liaison group between the medical profession and Michigan Hospital Service and to guide Blue Cross in matters medical. The Medical Advisory Committee to MHS represents the doctor of medicines' viewpoint.

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E. I. Carr, M.D., Lansing, was the recipient of an honorary degree from Cleary College, Ypsilanti, at its recent convocation. Doctor Carr was cited "in recognition of his service as a scholar, a surgeon and an administrator, reacting to the benefit of his community, the State and the Nation."

Doctor Carr's degree is Doctor of Science in Business Administration.

Congratulations, Doctor Carr!

Conrad A. Proctor, medical student at the University of Michigan, was the recipient of the First Prize Award and $500 cash in the Student American Medical Association Scientific Exhibit competition in Chicago, May 1-2-3. His prize-winning exhibit will be shown at the American Medical Association annual meeting at Atlantic City. The exhibit is entitled "The Development of Sensory Cell Innervation in the Inner Ear."

* * *

Genesee Makes Record at Cancer Clinic.—An interesting sidelight of the registration at Genesee's Cancer Day on April 22 was that more out of Genesee County

physicians attended than was the total registration of GCMS members. The Scientific Program featured Ulrich Henschke, M.D., New York City; Danely P. Slaughter, M.D., Chicago, Ill.; Freddy Homburger, M.D., Cambridge, Mass.; Owen H. Wangensteen, M.D., Minneapolis, Minn., and George T. Pack, M.D., New York. All speakers stressed continued adherence to early diagnosis of cancer and in general gave a review of the progress of cancer during the past 14 years with the following highlights:

People have become more cancer conscious; cancer is curable if diagnosed early; the public is less fearful of cancer because it has lost much of its mystery; great strides have been made in treatment of cancer (many cases were presented to exemplify this); to date there is no specific cure for the wild cancer cell; management has been improved to the great advantage of the patient.

H. B. Elliott, M.D., of Flint was Chairman of the Cancer Day Committee. The meetings were presided over by J. E. Livesay, M.D., President of Genesee County Medical Society, G. B. Saltonstall, M.D., Charlevoix, President of the Michigan State Medical Society, and James W. Logie, M.D., Grand Rapids, President of the Kent County Medical Society.

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A revised program for prospective medical assistants has been developed at Bay City Junior College through the co-operation of Bay County Medical Society, Bay County Medical Assistants Society and college business department.

The modernized program—resulting from a two-year re-evaluation study—will be inaugurated in September, 1959.

Some of the features are orientation to medical secretary work, talks by doctors and medical secretaries, field trips to doctors' offices, and orientation to public health vocations.

In addition, there will be training in shorthand, dictaphone, business machines, letter-writing, physiology and anatomy. During the second year courses in nursing arts and orientation to the medical laboratory will be offered. Students will also have the opportunity to work 12 hours weekly in offices of physicians.

In preparing the program, the Medical Society was represented by Drs. Walter L. Howland, Frederick J. Chapin, Harry F. Vail and Harold C. Shafer; the medical assistants by Mrs. Martha Hogel, Mrs. Arlene Bublitz, Mrs. Marcia Hornsby and Miss Joan Halstead.

* * *

Seven new developments in the voluntary health insurance business are resulting in the extension of protection to the Senior Citizens of the nation, according to the Health Insurance Association of America.

A recent HIAA report forecast that the proportion of older persons coming under the protection of health insurance "will continue on a rising trend approaching the relative extent of coverage owned by the population at the younger ages."

The seven recent developments include:

1. New issuance of individual insurance at advanced ages.

2. New issuance of group insurance to older people who are members of various types of associations.

3. Insurance coverage that becomes paid-up at age 65, thus enabling the policy-holder to defray protection costs during his productive years.

4. Continuation into the later years of individual insurance purchased at the younger ages.

5. Continuation of insurance on older active workers under group plans.

6. Continuation of group insurance for workers who retire and for their dependents, generally with part or all of the premium paid by the employer.

7. Continuation on an individual basis of coverage which originally was provided by group insurance.

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MEDICAL TELEVISION SHOWS PRODUCED BY MICHIGAN HEALTH COUNCIL

April 5, 1959—"Michigan Rural Health Conference" Otto K. Engelke, M.D., Ann Arbor, Sidney E. Chapin, M.D., Dearborn, and Robert G. Lovell, M.D., Ann Arbor

April 12, 1959—"Alcoholism"—(Films—"Out of Orbit" and "Alcohol in the Body")

April 19, 1959—"Heart"—(Film—"Fats and Heart Disease")

April 26, 1959—"Epilepsy and Tuberculosis—(Films—"Something Called Epilepsy" and "Are You Positive")

Ingham Clinic Attracts 275 M.D.s.—Three Michigan doctors of medicine were among the five featured speakers at the 31st annual May clinic of the Ingham County Medical Society. Held at the Olds Hotel, Lansing, May 7 with H. W. Harris, M.D., Ingham county president, presiding, the event highlighted addresses by Frederick C. Swartz, M.D., Lansing, about "Medicine in This Geriatric Age;" Joseph Schaeffer, M.D., Detroit, on "A Physical Medicine and Rehabilitation Service in a General Hospital," and Charles G. Child, III, M.D., Ann Arbor, on "Portal Hypertension."

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County medical society officers are invited to take advantage of the Merck Sharp and Dohme Postgraduate Program. Planned and administered by doctors of medicine to facilitate postgraduate medical education, the Merck Sharp and Dohme Program offers to arrange for speakers or to supply funds to support speakers already chosen. Requests for participation in this program should be directed to Frederick K. Heath, M.D., Merck Sharp and Dohme, Broad and Wallace Streets, Philadelphia, Pa.

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The United Cerebral Palsy Research and Educational Foundation announces several fellowship programs and invites applications. Both Clinical Fellowships and Medical Student Fellowships in cerebral palsy are offered, as well as Postdoctoral Fellowships in Brain Research. The Foundation is located at 321 West 44th Street, New York 36, N. Y.

THE DOCTOR'S LIBRARY

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

WHAT WE *DO* KNOW ABOUT HEART ATTACKS. By John W. Gofman, M.D., Professor of Medical Physics, University of California, Berkeley. 180 pages. Illus. New York: G. P. Putnam's Sons, 1958. Price, $3.50.

This is an interesting, well-printed and well-illustrated book endeavoring to explain in lay terms what is known today about the cause and control of atherosclerosis and coronary heart disease. It is a fascinating and intelligent discussion of the problem, written to inform the patient and his family of the mechanisms involved in heart attacks and the theory and experimental evidence concerned in their development. It is thought that an informed patient and family will carry out instructions of the physician better if they realize what is being done and why. The book goes into details in an interesting way for the patient of some intelligence, that the physician would never have time to do, were he able to do so.

This book is well worth the attention of every physician who deals with the problem, as suggested reading that he can provide for his patient which answers so many questions that the patient is hungry to know. I heartily recommend it.

R.W.B.

CANCER DIAGNOSIS AND TREATMENT. Edited by John B. Field, M.D., Ph.D., Assistant Clinical Professor of Medicine, University of Southern California School of Medicine, Los Angeles, California; with twenty-eight contributors. Boston, Toronto: Little, Brown & Company, 1959. Price, $18.50.

This handsomely printed, well-bound volume is designed for use by medical students, interns, residents, general practitioners and any physician interested in oncology. The book is a help to the physician in choosing the type of cancer treatment that seems indicated in the specific case. Early and proper choice of treatment for the cancer patient increases that patient's chances of survival significantly, and this book unquestionably aids the physician in this respect.

The book is edited by Dr. John B. Field with the help of twenty-eight well-selected contributors. It is divided into twenty chapters, each written by an authority on the subject. This volume is enthusiastically recommended as an addition to the physician's medical library.

J.W.H.

CHILDBEARING BEFORE AND AFTER THIRTY-FIVE. Biologic and Social Implications. A statistical study of the favored—and the less favored—years for human procreation. A book planned for college students and leaders of society who will show the way; the commonalty will follow, according to their lights. By Dr. Adrien Bleyer, Associate Professor Emeritus of Clinical Pediatrics, Washington University School of Medicine, St. Louis, Missouri. Introduction by Dr. Richard L. Jenkins, Director, Psychiatric Evaluation Project, U. S. Veterans Administration, Washington,

D.C. Commentary by Dr. Douglas P. Murphy, Associate Professor of Obstetrics and Gynecology, Gynecean Hospital Institute, University of Pennsylvania, Philadelphia. New York, Washington, Chicago, Hollywood: Vantage Press, 1959. Price, $2.95.

This is a very well-written, interesting book for lay people as well as medical individuals. The pros and cons of early pregnancies are thoroughly discussed, and the ideal age of eighteen to thirty for pregnancy is substantiated by numerous references and examples. The reasons for malformations, mental defectives and inferior children are explained in detail, with examples and references, together with their frequency as related to the age group of the mother, the age of the father having no bearing on the physical or mental health of the offspring.

This book is especially recommended for individuals who are anticipating marriage or who are engaged in marriage counseling work.

J.R.P.

SURGICAL PATHOLOGY. By Lauren V. Ackerman, M.D., Professor of Surgical Pathology and Pathology, Washington University School of Medicine, St. Louis, Missouri; Surgical Pathologist, Barnes Hospital and Affiliated Hospitals, St. Louis, Missouri; Consultant to the Armed Forces Institute of Pathology; in collaboration with Harvey R. Butcher, Jr., M.D., Associate Professor of Surgery, Washington University School of Medicine, St. Louis, Missouri. 1100 pages. 1114 illustrations. Second edition. St. Louis: The C. V. Mosby Company, 1959. Price, $15.00.

The new second edition of Surgical Pathology has been entirely revised. The book is a handsome hard-bound volume. The chapters are arranged to consider the surgical pathology of a system or organ (diseases of the skin, oral cavity, respiratory tract) and then proceed to specific organs. It contains chapters on bone and joint pathology, central nervous system pathology and diseases of the eye, all of which are often absent in books on general surgical pathology.

The book is profusely illustrated with excellent quality photographs. Some of these pictures demonstrate the iatrogenic diseases which are becoming more common with the increasing use of drugs and chemicals capable of altering cellular metabolism.

This is a book that any surgeon interested in surgical pathology should have in his library.

J.M.H.

MATERNITY: A GUIDE TO PROSPECTIVE MOTHERHOOD. By Frederick W. Goodrich, Jr., M.D. Illustrated by Victor Mays. Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1959. Price, $1.75.

This book is a step forward in helping with good prenatal care. It is of greatest value to the new mother and a help to those who are expecting to give birth again. The diagrams of the female anatomy and its changes in the pregnancy state are simple and easy for everyone to understand.

The book outlines and explains the purpose of visiting the doctor early and why he does certain things. It tells the expectant parent when to call the doctor and what

questions to ask him on her visits. It further explains her trip to the hospital and what to expect while she is there. The husbands role, her emotional changes, diet and the early care of the new baby are treated simply but in detail.

This book would be of great value as an adjunct to expectant parent courses.

J.R.P.

PHYSICAL DIAGNOSIS. The History and Examination of the Patient. By John A. Prior, M.D., Professor of Medicine, Ohio State University College of Medicine, Columbus, Ohio; Jack S. Silberstein, M.D., Clinical Associate Professor of Medicine, Ohio State University College of Medicine, Columbus, Ohio, and contributors. 193 illustrations. St. Louis: The C. V. Mosby Company, 1959. Price, $7.50.

This is a small, useful, well-printed textbook of physical diagnosis to be recommended primarily for the medical student. It is very well illustrated with both figures and photographs and represents the contribution of various members of the faculty of the Ohio State University College of Medicine.

The book is stripped of many non-essentials and sticks closely to the subject at hand. It is in no sense a textbook of medicine, nor should it be, but emphasizes strictly the procedure of doing a careful history and physical examination.

We are glad to see the deletion of eponyms and the dedication to essentials. The book is highly recommended.

R.W.B.

MEDICAL DEPARTMENT, UNITED STATES ARMY, SURGERY IN WORLD WAR II. Volume I. Neurosurgery. Prepared and published under the direction of Major General S. B. Hays, The Surgeon General, United States Army. Editor-in-Chief, Colonel John Boyd Coates, Jr., MC. Editors for Neurosurgery, R. Glen Spurling, M. D., Barnes Woodhall, M.D. Associate Editor, Elizabeth M. McFetridge, M.A. Washington, D.C.: Office of The Surgeon General, Department of the Army, 1958. Price, $5.00.

Volume I of a two-volume series is attractively bound with a hard cover. It deals with the management and treatment of head injuries in World War II.

Part I of the volume is concerned with the organization methods for the evacuation of head injuries from the time of injury to the arrival at a neurosurgical center. The methods described were used in the Mediterranean and European theatres of operations. Many of the lessons learned here could and should be used in treating mass casualties in military or civilian disasters of the future.

Part II deals with the actual treatment of head injuries from their immediate care at the time of inception on the battle field through the evacuation, neurosurgical techniques employed, types of operations, preoperative and postoperative care and long-term treatments of residuals such as epilepsy, speech defects, replacements with plastics.

The book is well illustrated with pictures, charts and graphs of excellent quality. It contains four appendices of special examination forms, and other material found to be very useful in World War II.

All of the contributors are well-qualified men in this field. Much of the material presented is directly applicable to civilian practice. The book is excellent in that it mentions failures as well as successes. With data and statistics that could be obtained only in a war, this volume is the most complete work in this important field in existence. It should be a valuable addition to any practicing physician's library.

J.M.H.

MEDICAL DEPARTMENT, UNITED STATES ARMY PREVENTIVE MEDICINE IN WORLD WAR II. Volume IV. Communicable Diseases Transmitted Chiefly through Respiratory and Alimentary Tracts. Prepared and published under the direction of Major General S. B. Hays, The Surgeon General, United States Army. Editor-in-Chief, Colonel John Boyd Coates, Jr., M.C.; Editor for Preventive Medicine, Ebbe Curtice Hoff, Ph.D., M.D.; Assistant Editor, Phebe M. Hoff, M.A. Washington, D. C.: Office of the Surgeon General Department of the Army, 1958.

This is Volume IV of a six-volume set which chronicles the history of Preventive Medicine in the Armed Forces of the United States in World War II. This volume deals with the military experience with those communicable diseases transmitted chiefly through the respiratory and gastrointestinal tracts, chiefly from the public health and military medicine standpoint.

This compendium of military information on the subject has been painstakingly compiled by an imposing panel of public health experts selected by reason of their experience and distinction in their special fields. Ex-

tensive statistical material and charts are presented. An introduction concerning general aspects of preventive medicine in World War II adds considerable interest in factual information.

The book is recommended as a valuable source book on the subject for the institutional medical library.

R.W.B.

CARDIAC ARREST AND RESUSCITATION. By Hugh E. Stephenson, Jr., M.D., Professor and Chairman, Department of Surgery, University of Missouri School of Medicine, Columbia, Missouri; Chief of Surgical Service, University of Missouri Hospitals; Associate-in-Charge, Cardiovascular Program, State Crippled Children's Service, University of Missouri; Consultant, Whiteman Air Force Base Hospital; Markle Scholar, John and Mary R. Markle Foundation, 1954-1959. St. Louis: The C. V. Mosby Company, 1958. Price, $12.00.

This is an up-to-date, carefully planned, and well-organized treatise on the subject of cardiac arrest and resuscitation which is the result of some eight years of dedicated effort. Logical development and presentation of the subject, the etiology, management, prevention, and prognosis make it a useful and readable compendium on this timely subject.

The chapter on management includes complete instructions for emergency thoractomy and cardiac massage and places responsibility for such on the nearest available physician regardless of specialty or training. The folly of hesitation to institute such treatment once arrest or fibrillation have been thought to occur is emphasized. Closed chest needle puncture is considered ill advised.

Medicolegal aspects of the procedure are discussed by proper authority.

Detailed care of the post-resuscitative patient as well as preventive measures are discussed, and a chapter on elective arrest for open heart surgery is included.

An extensive bibliography is appended.

This is a practical book, well-written, interesting to read, and well-illustrated, satisfying a genuine need. It should be a part of the hospital library.

R.W.B.

HEY GROVES' SYNOPSIS OF SURGERY. Edited by Sir Cecil Wakeley, Bt., K.B.E., C.B., LL.D., M.Ch., D.Sc., F.R.C.S., F.R.S.E., F.A.C.S., F.R.A.C.S., Past President of the Royal College of Surgeons of England; Fellow of King's College, London; Consulting Surgeon to King's College Hospital and Belgrave Hospital for Children; Senior Surgeon, Royal Masonic Hospital; Consulting Surgeon to the Royal Navy; Examiner in Surgery to the University of Liverpool; formerly Examiner in Surgery to the Universities of Bristol, Cambridge, Durham, Glasgow, London, and Sheffield; and to the National Universities of Ireland and Wales. Fifteenth edition. Illustrated. Baltimore: The Williams and Wilkins Company, 1958. Price, $8.50.

This clothbound handbook of surgery in its fifteenth edition is apparently intended for students reviewing the general subject of surgery. The author has attempted to

bring the book up to date, and he includes some of the recent advances in vascular surgery and some of the newer antibiotics. However, there is a lag of about five years in the use of prosthetic devices in vascular surgery and in treatment with the more recent antibiotics.

The book is set up to give the reader a panoramic view of the entire field of surgery and is necessarily rather brief as a result. The material is presented in a practical and logical form so that it is possible to follow through all diseases in essentially the same way: etiology, distribution, pathology, clinical signs, differential diagnosis and treatment. The sketches are clear, brief, to the point, and there are a number of color plates demonstrating various anatomical relationships.

This book is probably to be used in preparing for a college or board examination rather than as a reference book, and should be very popular with students. It could be of value to anyone organizing the vast amount of material found in present-day surgery. It is a book, however, that many men would not keep on their book shelves because it is too brief and is merely an outline covering all the aspects of the entire field of surgery.

J.M.H.

THE SEDIMENTATION RATE OF HUMAN ERYTHROCYTES. Its Basic Concepts—Its Value as a Differential Diagnostic Agent—Its Multiple Clinical Applications. By Frank Wright, M.D., F.A.C.P., F.A.S. 43 pages. New York: Vantage Press, 1959. Price, $2.50.

This is a small volume discussing primarily the sedimentation rate of human erythrocytes and the many implications derived therefrom. It is a rather rambling dissertation, whose "raison d'etre" is a bit difficult to understand. Embodied in the discussion is a plea against further atomic detonation.

R.W.B.

A definite diagnosis of bronchiogenic cancer cannot be made on a histological basis.

* * *

Mikulicz's syndrome is characterized by symmetrical enlargement of the salivary and lachrimal glands.

* * *

In cases of suspected pulmonary tuberculosis where no tubercle bacilli could be demonstrated by smears, cultures or animal inoculations, cancer must be strongly suspected and cytological examinations carried out.

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